NACOGDOCHES
G.I. CONSULTANTS
PLLC

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

SEND RECORDS TO:

Facility and Provider Name (or Self): _____

Address: _____

City, State, Zip: _____ Phone/Fax: _____

FROM:

Facility and Provider Name (or Self): _____

Address: _____

City, State, Zip: _____ Phone/Fax: _____

RECORDS TO RELEASE:

Describe the purpose of disclosure: _____

By initialing the spaces below, I authorize the release of the following protected health information:

_____ Hospital records _____ Laboratory reports _____ Pathology reports
_____ Procedure reports _____ Most recent five-year history _____ Office notes
_____ Imaging reports _____ Other: _____

SPECIAL AUTHORIZATION:

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS related records _____ Genetic testing information
_____ Mental health information _____ Drug/Alcohol diagnosis, treatment or referral information

_____ *Requesting records in paper form* _____ *Requesting records in electronic form*

_____ This authorization is limited to the following treatment and/or time period: _____

_____

Signature: X_____ Date: _____

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services represent research-related treatment and the authorization is necessary to participate in the research study and receive research-related treatment. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to our office and state you are revoking your authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information, and may specifically require my authorization prior to redisclosure. This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing, or shall remain in effect for the period reasonably needed to complete this request