PREMIER MEDICAL GROUP
GASTROENTEROLOGY ASSOCIATES
243 NORTH ROAD SUITE 304
POUGHKEEPSIE, NY 12601
PHONE: 845-471-9410 FAX: 845-471-7943

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: ______________________________

DATE OF BIRTH: __________________

ADDRESS: ________________________________

____

TELEPHONE: ____________________

I hereby authorize ____________________ to disclose the following Protected Health Information (PHI) to ______________________.

PHYSICIAN PHONE: ____________ FAX: ______________

The following information is to be disclosed: (please check off those that apply)

Physician notes _______ Dates __________
Lab results _________ Dates __________
X-Ray reports ________ Dates __________
Operative reports _____ Dates __________
COMPLETE RECORD _______
Other: __________

The PHI to be used or disclosed for the following purposes:

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I understand that the information in my record may include information relating to sexually transmitted diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), or infection of the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug abuse.

GASTROENTEROLOGY ASSOCIATES will not determine my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide an authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal of State laws.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: (if I do not specify an expiration date, event or condition, this authorization will expire in one year from the date signed).
DATE: ____________________

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Signature of patient of patient representative

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Date