AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) to PHYSICIAN

Print Patient Name First _____ Middle _____ Last _____ Suffix__

Date of Birth (MM/DD/YYYY):_____ Last 4 digits of SS#:_____

Mobile Number: _____ Land Line: _____ E-mail: _____

I hereby authorize the release of my Protected Health Information (PHI) as described below. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal privacy regulations as per the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Your PHI is to be released by Gastroenterology Associates of Cleveland, Inc.
https://www.gastro-associates.com

Your PHI is to be released to your PHYSICIAN
Name:
Address:
City, State, Zip:
Telephone:
Fax:

The PHI to be disclosed: (please check all that apply)		
Complete Record: ◯ Yes ◯ No	Office Notes: ◯ Yes ◯ No	Procedure Reports: ◯ Yes ◯ No
Medical History: ◯ Yes ◯ No	Diagnostic Tests: ◯ Yes ◯ No	Send Via: ◯ Mail ◯ Fax

Patient Signature:	Date:
Guardian Signature:	Date
Signature of Patient Representative: (If patient unable to sign or deceased)	Date:
Relationship to Patient:	

This signed copy will be retained for life in your file as to the extent provide for by law.
You may request a copy of the Release at any time.
This practice reserves the right to refuse service if this Release is not properly executed.