GASTRO ONE
G.I. DIAGNOSTIC AND THERAPEUTIC CENTER, L.L.C.

PATIENT AUTHORIZATION
FOR USE / DISCLOSURE OF HEALTH CARE INFORMATION

☐ 3350 N. Germantown Rd.		Telephone (901) 377-2111	Fax (901) 377-5105
☐ 6005 Park Ave., Suite 323-B		Telephone (901) 684-5500	Fax (901) 684-5518
☐ 7668 Airways Blvd.	MS	Telephone (662) 349-6950	Fax (662) 349-6634
Building B	TN	Telephone (901) 766-9490	
☐ 1407 Union Ave., Suite 1400		Telephone (901) 272-9296	Fax (901) 272-1786
☐ 1310 Wolf Park Dr.		Telephone (901) 624-5151	Fax (901) 624-5280
☐ 1324 Wolf Park Dr.		Telephone (901) 755-9110	Fax (901) 755-4321
☐ 76 Capital Way Cove, Suite E		Telephone (901) 377-2111	Fax (901) 377-5105

Patient's name: ____

Address: ____

____

Telephone: ____________________ Date of birth: ____________ SSN: ______________

I, the undersigned, authorize and request Gastro One and/or G.I. Diagnostic and Therapeutic Center, L.L.C. to

__________Release information to ____________ Obtain information from

Name:____

Address: ____

City, ______________________ State: ________________ Zip code:________________

This request and authorization applies to:

____ Complete Health Record ____Operative Report ____ Lab Results

____ Pertinent Documentation ____ History and Physical ____ Consultation Reports

____ Progress Notes ____ EKG ____ EEG ____ Discharge Summary

____ X-Ray Report ____ X-Ray Film / Images ____ Photographs, Videotape

____ Complete Billing Record ____ Itemized Bill

☐ Other: ____
(specify)

Drug and /or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted diseases, Hepatitis B or C, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) and/or other sensitive information regarding counseling, treatment, rehabilitation or the risk thereof. I agree to its release.

Time Limit & Right to Revoke Authorization

Except to the extent action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Gastro One or by filling out a form supplied by Gastro One known as the *Revocation of Authorization Form.* Unless revoked, this authorization will expire on the following date or event __________

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or one year from the date of signature, unless otherwise specified. Once Gastro One gives out the information that I want released, I know that Gastro One has no control over the information. The individual ororganization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information. I understand I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with two exceptions:

1. Refusal to sign this authorization, if it is not for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment.
2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

I understand I can refuse to sign this authorization. I need not sign this form to obtain medical treatment, payments, or health plan enrollment eligibility. I understand that any disclosure of information carries with it the potential for re-disclosure by the recipient and that the information may then no longer be protected by federal confidentiality rules.

Patient Signature: ____________________________________ Date: ________________

Authority to sign, if not patient: ____________________________

Relationship to patient: ____________________________

Gastro One Use Only
Identity of Requester Verified by:

☐ Photo ID ☐ Matching Signature ☐ Other, specify ________________________

Verified by: ____
(name / title and date)