

Gastroenterology Associates, Inc.
Authorization for Release of Protected Health Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I hereby authorize and consent to disclosure of health records as stated below. Unless limited below, I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law (IC 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding alcohol abuse, substance abuse, communicable disease documentation, human immunodeficiency virus (HIV), or mental health treatment or counseling.

- 1. Information to be disclosed (dates of service): \_\_\_\_\_
[ ] Office Visit/Progress Notes
[ ] Laboratory Reports
[ ] Radiology Reports (x-ray, CT, MRI, etc.)
[ ] EKG/Cardiac Testing
[ ] Other: \_\_\_\_\_
[ ] I authorize the release of information protected by Federal and State Regulations including alcohol/substance abuse, mental health documentation, and HIV results.

2. I authorize \_\_\_\_\_ to release information to:

EAST OFFICE

Gastroenterology Associates
1400 N. Ritter Avenue, Suite 370
Indianapolis, IN 46219 Tel 317-355-1144
FAX : 317-355-1155

NORTH OFFICE

Gastroenterology Associates
7950 N. Shadeland Avenue, Suite 350
Indianapolis, IN 46250 Tel 317-578-2600
FAX : 317-578-6474

3. I authorize \_\_\_\_\_ to obtain information from:

GASTROENTEROLOGY ASSOCIATES, INC.

4. The purpose or need for this disclosure is: [ ] at the request of the individual [ ] other \_\_\_\_\_

5. This authorization is valid for as long as reasonably necessary to fulfill the purpose for which it is given. This will not exceed 60 days from the date of signature.

6. This authorization may be revoked at any time, except to the extent that action has already been taken. To revoke this authorization, I will notify the Privacy Contact in writing.

7. Information to be released in the following manner:
[ ] Verbally [ ] Photocopy [ ] Faxed

8. I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

Signature of Patient or Personal Representative

Date

If Personal Representative:

Name of Personal Representative

Description of Representative's Authority to act for the patient