[GI NORTH, P.C.]

Authorization for Use or Disclosure of Protected Health Information

PATIENT NAME_____
LAST **FIRST** **MI**

DATE OF BIRTH: ____/____/____ **SS#:**____-____-____ **MEDICAL RECORD #**_____

_____
ADDRESS **CITY** **STATE** **ZIP**

DAY PHONE:_____ **EVENING PHONE:**_____

☐ I authorize [Practice Name] to use or disclose my protected health information as indicated below to:

_____
Name of entity to receive this information

_____
ADDRESS **CITY** **STATE** **ZIP**

_____
PHONE NUMBER **FAX NUMBER**

☐ authorize_____
Name of entity to release this information

To release my protected health information to [Practice Name] as indicated below.

INFORMATION TO BE RELEASED:

- ☐ From & To Dates _____
- ☐ History and physical exam
- ☐ Office notes
- ☐ X-ray reports
- ☐ Lab reports
- ☐ Hospital records (op notes, discharge summary)
- ☐ Medication records
- ☐ Other: _____

PURPOSE OF DISCLOSURE:

- ☐ Changing physicians
- ☐ Continuing care
- ☐ At patient request
- ☐ Second opinion
- ☐ Legal
- ☐ Insurance/Workers' Compensation
- ☐ School
- ☐ Other: _____

I understand that this authorization will expire: _____
Expiration Date or Defined Event

I understand that I may revoke this authorization at any time by notifying [GI NORTH, P.C.] in writing. Th authorization will cease to be effective on the date notified except to the extent that the Practice has acted in trust upo this authorization.

_____ _____
Signature of Patient or Legal Guardian Date

Effective Date:_____

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