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Release of Information Authorization

Patient Name:_____ **Date of Birth:** _____

Previous Name (if applicable):_____ **SSN:**_____ **Account #:** _____

Person/Organization providing the information:

_____
_____
_____

Person/Organization receiving the information:

_____
_____
_____

Specific description of information: (Please indicate treatment dates for each requested item)

☐ Office Notes From _____ to _____ ☐ Radiology Reports From _____ to _____

☐ Lab Reports From _____ to _____ ☐ Pathology Reports From _____ to _____

☐ Procedure Reports From _____ to _____ ☐ Entire Record (all documents listed above without exception)

☐ Other (specify) _____

The information described above will be used or disclosed for the following purpose(s):

☐ Continuity of care ☐ Moving ☐ Transfer of care ☐ Disability determination ☐ Insurance

☐ Patient's copy ☐ Attorney request ☐ Other (specify): _____

To be completed by the patient or personal representative:

I hereby authorize the use or disclosure of my protected health information as described above. I understand that this authorization is voluntary and the refusal to sign this authorization will not in any way affect my ability to obtain treatment. I understand that Gastroenterology, Ltd. will provide this information within 15 days from the receipt of the request and that a fee for preparing and furnishing this information may be charged according to the rulings set forth by the Virginia Statutory Code. I understand that any confidential information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law. I understand that I have a right to revoke this authorization by notifying Gastroenterology, Ltd. in writing. Any revocation will not affect uses or disclosures of my confidential information that occurred prior to Gastroenterology, Ltd.'s receipt or knowledge of the revocation.

_____ _____ _____
Signature of patient or patient's representative Printed name of patient's representative Relationship to patient

Date: _____

Expiration date of authorization: _____ (Unless otherwise noted, this authorization will expire 12 months from the date of signature)