

THE GASTROENTEROLOGY GROUP, P.C.

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ Account Number: _____

Address: _____

Date of Birth: _____ Phone #: _____

PERSON/ORGANIZATION PROVIDING INFORMATION: _____

ADDRESS: _____

PHONE #: _____ FAX #: _____

PERSON/ORGANIZATION RECEIVING INFORMATION: _____

ADDRESS: _____

PHONE #: _____ FAX #: _____

PURPOSE OF DISCLOSURE:

- Legal Insurance Employer
 Further medical care Personal use Other (please specify): _____

DATES OF TREATMENT:

INFORMATION REQUESTED:

- Emergency Dept. Record Discharge summary EKG/cardiac studies Entire record
 Lab results History and physical Physical medicine
 Pathology reports Operative Report Behavioral health
 X-ray/medical imaging Consultation report Medication records

I understand that:

- The information in my health record may include information about behavioral or mental health services or treatment for alcohol and drug abuse. It may also include information related to genetic testing, treatment or testing for sexually transmitted disease, HIV or AIDS.
- This authorization is voluntary and I do not need to sign this form to ensure healthcare treatment.
- I may inspect or copy the information used or disclosed under this authorization.
- Once this information is disclosed, it may be redisclosed by the person or organization receiving the information and that information may no longer be protected by federal privacy laws or regulations.
- I have the right to revoke this authorization at any time by notifying the Health Information Management Department in writing. I understand that this revocation will not apply to information that has already been released.
- This authorization will expire in ninety (90) days from the date signed below; or upon the following date, event or condition: _____

Signature of Patient or Legal Representative _____ Date _____

If signed by a legal representative, please indicate relationship to patient: _____

Date received:	Method of disclosure: ____ Mail ____ Fax ____ In person pick-up	Completed by:	Date Completed:
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