Patient Authorization to Use or Disclose Protected Health Information

I, _____, understand The Center for Gastrointestinal Disorders is authorized by me to use or disclosure my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of The Center for Gastrointestinal Disorders, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (check all that apply):

☐ The patient's entire medical record
(NOTE: This requires an explanation why the entire record may be disclosed).

☐ The patient's demographic information (check all that apply):

☐ Name ☐ Address ☐ State/Zip Code only ☐ Telephone

☐ Age ☐ Gender ☐ Race ☐ Other: _____

☐ Medical Data/Information as related to:

☐ Specific condition(s): _____

☐ Specific professional service(s): _____

☐ Specific medication(s): _____

☐ Other: _____

☐ Other: _____

Name(s) or class of person(s) other than current employees or owner(s) authorized by this form to disclose the patient's protected health information:

_____

_____

Name(s) or class of person(s) authorized by this form who may receive the patient's protected health information:

_____

_____

Purpose(s) of the information:

_____

_____

☐ (Check if applicable) This authorization is to be used for our own use, and The Center for Gastrointestinal Disorders will not condition treatment or payment on this authorization. Moreover, the patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

☐ (Check if applicable) The patient understands that The Center for Gastrointestinal Disorders may receive financial gain as a result of disclosing this information due to:

_____

_____

☐ (Check if applicable) This authorization permits The Center for Gastrointestinal Disorders to send the protected health information ONLY to this address or fax number:

_____

_____

Any other address or fax number is not permitted by this authorization.

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this

authorization to be effective, The Center for Gastrointestinal Disorders must receive the revocation in writing. The revocation must include:

- $ The patient's name, address, and patient number, if applicable,
- $ The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- $ The patient's desire to revoke this authorization, and the date of the revocation, and the patient's signature.

The Center for Gastrointestinal Disorders will accept written revocations of this authorization via:

☐ Certified U.S. mail
☐ Facsimile at this number: 954-961-9633

ALL revocations must be sent to The Center for Gastrointestinal Disorders to the attention of the Privacy Officer, Lorna Walker, Ph.D., and are not effective until received by the Privacy Officer.

This authorization shall expire on _____. After this date, The Center for Gastrointestinal Disorders can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____
Patient's Signature Date

FOR OFFICE USE ONLY

Authorization added to the patient's medical record on _____
(Date)

Authorization verified by _____ on _____
(Witness) (Date)