

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I, _____, Date of Birth _____,

Telephone No. _____, voluntarily authorize Hamilton

Gastroenterology Group to release my:

- entire record
- problem list
- list of all medications
- most recent history and physical
- most recent discharge summary
- lab results as defined: _____
- consultation reports from : _____
- other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS, HIV or Hepatitis. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

The information identified above may be used by or disclosed to the following individuals or organization(s):

NOTE: PLEASE PROVIDE ENTIRE ADDRESS

Name: _____

Address: _____

Name: _____

Address: _____

I understand that I have a right to revoke, in writing, this authorization at any time. This authorization will expire _____. If I fail to specify an expiration date, it will expire six months from the date on which it was signed.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws.

Signature of Patient

Date

Signature of Witness

Date

(Distribution: Original in patient chart, copy to patient, copy to accompany disclosure)