AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name:

Patient's Date of Birth: Contact#:_______________

TO: ______________________________________FAX:_____________________________

(PHYSICIAN'S NAME) FAX IS REQUIRED PLEASE

Please release my Protected Health Information to:Metro Atlanta Gastroenterology, LLC

FAX:404-255-0601ADDRESS:5669 Peachtree Dunwoody Rd., Suite 210, Atlanta, GA 30342

(Person(s) or Organization(s) authorized to receive the information)

Specific description of the information that may be used or disclosed

Office notes________ EKG/Cardiac Tests______Endoscopy Reports_____

X-Ray Reports______ Lab Reports______Pathology Reports:_______

All Records_________ Other___________________________________

Specific description of how the information will be used: Medical Treatment

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1) I understand that this authorization will **not expire until I revoke my authorization.**
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying *(insert name of practice)* in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

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Patient's Signature or Patient's Representative Date

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Printed Name of Patient's Representative Relationship to Patient