**Authorization For Disclosure of Patient Health Information (PHI)**

Gastroenterology Clinic, APMC (Entity)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient’s date of birth), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient’s social security #), hereby authorize the **Gastroenterology Clinic** to **Disclose / Receive** the following protected health information **To / From:**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City, State, Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please √ to specifically authorize the use and/or disclosure of:**

\_\_\_\_History & Physical \_\_\_\_Progress Notes \_\_\_\_Consultation Report \_\_\_\_Laboratory Reports

\_\_\_\_Discharge Summary \_\_\_\_Nurses Notes \_\_\_\_Billing Statements \_\_\_\_Pathology Reports

\_\_\_\_X-Ray Reports \_\_\_\_Procedure Notes \_\_\_\_Medication History

\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This protected health information is being used or disclosed for the following purposes:

\_\_\_\_Continuing Medical Care \_\_\_\_Personal Use \_\_\_\_Legal Purposes \_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization shall be in force and effect until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date) at which time this authorization to disclose this protected health care information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the Entity. I understand that a revocation is not effective:

● To the extent that this Health Care Provider has relied on the use or disclosure of the protected health information; or if

 the authorization is obtained as a condition of obtaining insurance coverage, if some other law or the policy itself

 provides the insurer with the right to contest a claim under the policy.

I hereby authorize Entity to obtain/release the health information indicated above that is contained in my patient records to the Recipient named above. **I understand that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy Notes requires a separate authorization. Psychotherapy Notes are defined as notes that document private, joint, or family counseling sessions that are separated from the rest of a patient’s medical record.**

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that the Entity may not condition my treatment, payment, enrollment in a health plan, or eligibility (if applicable) on whether I provide this authorization for the requested use or disclosure.

I understand that I have the right to:

● Inspect or copy the protected health information to be used or disclosed as permitted under federal law, or state law

 to the extent the state law provides greater access rights; and

● Refuse to sign this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Representative\*\* Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Representative’s Authority Witness

\*\*If other than the patient’s signature, a copy of legal paperwork verifying the patient’s personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for healthcare). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.

\*\*For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.

**A copy of this document must be provided to the patient when executed.**

611 Grammont St. ● Monroe, LA 71201

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