AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Previous Name: _____

Date of Birth: _____ SSN: _____

Released From: I request and authorize: Associates in Gastroenterology 2940 North Circle Drive Colorado Springs, CO 80909 Phone: 719-635-7321 Fax: 719-635-2510 To release healthcare information of the patient named above to:		Released From: I request and authorize: Name: _____ Address: _____ City/State _____ Zip Code _____ To release healthcare information of the patient named above to:
Released to Name: _____ Address: _____ City/State _____ Zip Code _____		Released To: Associates in Gastroenterology 2940 North Circle Drive Colorado Springs, CO 80909 Phone: 719-635-7321 Fax: 719-635-2510

This request and authorization applies to:

_____ ALL Healthcare information

_____ Healthcare information relating to the following treatment, condition or dates of treatment:

_____

_____

_____ Other

_____

_____

(I understand that my express consent is required to release any healthcare information relating to: add provisions required by state or federal law such as information about HIV, STD's, mental health, and substance abuse).

_____ _____

Signature of patient or authorized representative Date signed

_____

Relationship or status if signed by anyone other than patient

This authorization expires on: _____ or _____ days after the date it is signed, or when the following event occurs: _____

I may cancel this authorization to the extent allowed by the law. If I do, I understand that Associates in Gastroenterology, P.C. may have already released or received information about me after I gave my permission. I know that canceling this authorization would not prohibit any release of information by Associates in Gastroenterology, P.C. in reliance on my original authorization.

There are two ways to cancel this agreement:

1. Sign and date a form available from Associates in Gastroenterology, P.C. called "Revocation of Authorization for Use and Disclosure of Healthcare Information" or
2. Write a letter to Associates in Gastroenterology, P.C. If I write a letter to Associates in Gastroenterology, P.C. it must say that I want to cancel my authorization to disclose healthcare information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I(or my authorized representative for healthcare) must sign and date this letter

Once Associates in Gastroenterology, P.C. gives out the information or receives the information that I want released, I know that Associates in Gastroenterology, P.C. has no control over the information. The individual or organization that I authorized to receive or release information might re-disclose it. Federal and State privacy laws may no longer protect the information.

*This form is not sufficient to authorize research-related treatment, to authorize psychotherapy notes, to allow disclosures of Protected Health Information (PHI) by others, or to authorize uses and disclosures for the physician's or clinic's own purposes, such as for marketing purposes.