GASTROENTEROLOGY ASSOCIATES

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1600 Willow Creek Rd • Prescott, AZ • 86301
P: 928-608-5500 • F: 928-608-5508

Patient's Consent of Disclosure of Medical Information

Date: _____

Patient's Name: _____ Date of Birth: _____

□ Other Provider: _____

I, _____, do hereby consent to disclosure of confidential medical, psychiatric, or psychological testing or treatment records by the above-named provider or facility to:

Gastroenterology Associates 1600 Willow Creek Rd. Prescott, AZ 86301 (Phone 928.608.5500 / Fax 928.608.5508)

Information to be released is to include:

- ❑ Hospital discharge summaries
- ❑ Hospital histories and physical examinations (PE), progress notes
- ❑ Laboratory reports
- ❑ ECG tracings and reports
- ❑ Physician office records including history, PE's, progress notes
- ❑ Medical consultation reports
- ❑ Psychiatric and/or psychological testing, consultations, progress notes
- ❑ Operative/surgical/procedure reports
- ❑ Pathology reports/Pap smear reports
- ❑ X-ray, MRI< CT scan, Ultrasound, and all other imaging studies reports
- ❑ Other: _____

Information is to be released for the following purpose: _____

I understand that GA may not condition treatment on whether I sign this authorization. However, GA may refuse to provide treatment or provide services unless I sign this authorization if:

(1) The treatment is research-related treatment and the authorization is needed to use or disclose protected health information ("PHI") for such research [this form has been so conditioned _____], or **
initials

(2) For services conducted solely to produce information for a third party and the authorization is for the disclosure of the PHI for that third party [this form has been so conditioned _____]. **
initials

This form has not been conditioned unless one of the two blanks above has been initialed.

I understand that I may refuse to sign this authorization, subject to the above conditions. If I sign this form, I am entitled to a copy of the signed authorization.

I understand that PHI disclosed pursuant to the authorization may be disclosed if the recipient(s) as described on this form is not required by law to protect the privacy of the information and that in such a case, the PHI disclosed may no longer be protected by HIPAA and other federal and state privacy laws.

GASTROENTEROLOGY ASSOCIATES, P.C.

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Patient's Consent of Disclosure of Medical Information (continued)

I understand that I may revoke this authorization at any time by giving written notice to GA, except to the extent that action has already been taken in reliance on this authorization. Without such revocation, this authorization will expire on _____ (date), or if left blank, 12 months from the date of my signature, or as of the action or event of: _____.

I am aware that records to be released may contain Drug/Alcohol Use/Abuse Information and/or Psychological/Psychiatric information, which information is protected by Federal Law. Federal Regulations prohibit further disclosure of such information without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This also allows release of any and all information regarding HIV or AIDS status testing, therapy, and risk factors.

Patient identification information:

Name: _____ Prior or Maiden Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ Phone Number: _____

_____

_____ _____
Signature of patient Date

_____ _____
Signature of parent or guardian, if patient is a minor Date

_____
Printed name of parent or guardian

_____ _____
Signature of representative Date

_____ _____
Printed name of representative Authority of representative to sign on patient's behalf, e.g. power of attorney
(please provide a copy of the legal document)