To be completed and submitted to office staff.

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient: _____ Date of Birth: _____

Tri-County Gastroenterology, PC is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient, or others, in keeping with the patient's instructions.

ENTITY TO RECEIVE INFORMATION Check each person/entity that you ✓ approve to receive information.	**DESCRIPTION OF INFORMATION TO BE RELEASED** Check each that can be given to person/entity ✓ on the left in the same section.
_____ Voice Mail	_____ Account information _____ Appointment information _____ Medical information (prescriptions, results, treatment, etc.)
_____ Spouse Spouse's Name:_____	_____ Account information _____ Appointment information _____ Medical information (prescriptions, results, treatment, etc.)
_____ Parent(s) Name: _____ Name: _____	_____ Account information _____ Appointment information _____ Medical information (prescriptions, results, treatment, etc.)
_____ Son / Daughter Name: _____ Name: _____	_____ Account information _____ Appointment information _____ Medical information (prescriptions, results, treatment, etc.)
_____ Other Name: _____ Relationship: _____	_____ Account information _____ Appointment information _____ Medical information (prescriptions, results, treatment, etc.)

Patient Information – I understand that I have the right to revoke this authorization at any time and that I have the right to inspect a copy of the protected health information to be disclosed, as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in effect until revoked by the patient.

Signature: **X** _____ Date: **X** _____

Signature of PATIENT (or personal representative*)

_____

*If signed by personal representative, please provide description of authority (attach necessary documentation)