High Desert Gastroenterology Inc.
Authorization for Disclosure of Protected Health Information

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to patient.

I hereby authorize (name of provider/address/phone & fax numbers):

_____

_____

_____

To disclose the following information from the health records of:

Name: _____
Last First MI Previous Name

Birth date: _____ Social Security #: _____

Telephone: (H) _____ (C) _____ (W) _____

Address: _____
Street City State Zip

This information is to be disclosed to:

_____

_____

_____

Covering the periods of healthcare (Date(s) of service):

From (date): _____ to (date): _____

For the purpose of: _____
(Not required if the disclosure is requested by the patient)

The following information may be released:

_____

_____

_____

I understand that this will include information relating to (check and initial, if applicable):

_____Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection.
_____ Behavioral health service/psychiatric care.
_____Treatment for alcohol and/or drug abuse.

If compensation will be received:

I understand that _____ will receive compensation for its use/disclosure of the information pursuant to this authorization. Patient's initial's _____.

Affirmation of Release:

I give _____ or named agency permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only the purposes I have checked. I understand that the release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation of refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records during hospitalizations and after discharge. Copies of the records may be obtained with reasonable notice and payable of coping cost. I further understand that if the person or entity receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulation or a business associate of these entities, the information described above may be re-disclosed and no longer protected by regulations.
Please be advised that the turn around time for processing/coping records could take up to 14 business days.

_____ _____

Signature of the Patient/ Guardian/Legal Representation Date Signed

_____ _____

Signature of Witness/ Relationship to Patient Date Signed

Expiration date: _____
One year from date signed

For office use only:

Received: _____

Patient's account number: _____

Released: _____

Initials: _____

Notes: _____

_____