

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

Name of Patient/Previous Names

Birth Date/Medical Record Number

Street Address

City, State, Zip

INFORMATION RELEASED FROM:

INFORMATION RECEIVED BY:

Tri-State Gastroenterology Associates

TO: _____

425 CentreView Blvd.

Name

Crestview Hills, Ky. 41017

Street Address

City, State, Zip Code

INFORMATION TO BE RELEASED:

Dates of treatment: _____
(if no date is indicated most current will be released)

Office Consults/Follow-up Reports Procedure Reports Hospital Reports
 Laboratory Reports Radiology Reports
 Entire Record (Designated Record Set to include procedures, office consults/follow-ups, labs, radiology)
 Other (specify): _____

In compliance with Ky. Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

Mental Health Developmental Disabilities Alcoholism
 HIV (AIDS) Sexually Transmitted Disease Drug Abuse
 Other (Specify): _____

For the Following Date(s): _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

Further Medical Care Legal Investigation or Action Personal
 Insurance Eligibility/Benefits Changing Physicians
 Other (Specify): _____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Privacy Office of Tri-State Gastroenterology Associates. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: the Privacy Officer for Tri-State Gastroenterology Associates. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for 90 Days from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP: _____ **DATE:** _____
(If signed by other than patient, state relationship and authority to do so.)

WITNESS: _____