Gastroenterology of the Rockies

PROTECTED HEALTH INFORMATION (PHI) AUTHORIZATION FORM

I, ______________________________ ______________________ **, authorize**
Patient's Name Patient's Date of Birth

Gastroenterology of the Rockies and its employees to use and/or disclose my Protected Health Information from ______________ **to** ______________ **as indicated below to:**
Date (mm/dd/yyyy) Date (mm/dd/yyyy)

____
Name of Person and/or Company

______________________ ______________________
Daytime Telephone # Fax Telephone #

____
Address

______________________ ______________ ______________
City State Zip Code

INFORMATION TO BE RELEASED:

- ☐ Office Visits/ Progress Notes
- ☐ Pathology / Lab Results
- ☐ Hospital / Operative / Procedures Reports
- ☐ X-ray / Imaging Reports
- ☐ Insurance / Billing Information
- ☐ Other: ______________________________

I specifically authorize disclosure of the following conditions (check all that apply):

- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ HIV/AIDS
- ☐ Sickle Cell Anemia
- ☐ Behavioral Health Services/Psychiatric Care (incl. Notes)
- ☐ Genetic Testing

REASON FOR REQUEST:

- ☐ Changed Insurance
- ☐ Moving out of Area
- ☐ Change of Doctor
- ☐ Other: ______________________________

We may not condition your right to receive health care services from us upon your signing this authorization. However, if the treatment to be provided is for research purposes, your failure to sign this authorization will prevent us from providing such treatment.

When we use or disclose your health information to other parties as you have instructed in this authorization, we will not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such a situation, your disclosed health information may no longer be protected by federal and state privacy laws.

I understand the following: Without my express revocation, this authorization will automatically **expire** 365 days from the date signed below, unless I request an expiration date less than 365 days. I may choose to **revoke** this authorization at any time, except to the extent that the action has already been taken to comply with it, by notifying Gastroenterology of the Rockies in writing.

I have a right to receive a copy of this authorization upon my requesting it.

______________________________ ______________
Patient's or Legally Authorized Person's Signature Date

Gastroenterology of the Rockies – Medical Records
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