

**Patient Authorization for Release of Protected Health Information**

I hereby authorize the Practice, or any of its employees, staff or agents, to use and disclose health information from the medical record(s) of: *(please print)*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ SSN (last four): \_\_\_\_\_

**RELEASE INFORMATION FROM:**

*Specify the name of the  
Individual or Organization*

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Fax: \_\_\_\_\_

**RELEASE INFORMATION TO:**

*Specify the name of the  
Individual or Organization*

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Fax: \_\_\_\_\_

**REASON FOR RELEASE:**

\_\_\_\_\_ Continuing Medical Treatment  
 \_\_\_\_\_ Other \_\_\_\_\_

Type of Information: *(check all that apply)*

\_\_\_\_\_ Entire Medical Record      \_\_\_\_\_ Dictated Reports      \_\_\_\_\_ Progress Notes  
 \_\_\_\_\_ Lab Results      \_\_\_\_\_ Consultations      \_\_\_\_\_ Procedures  
 \_\_\_\_\_ Nuclear Medicine      \_\_\_\_\_ Referral      \_\_\_\_\_ X-Rays  
 \_\_\_\_\_ Other \_\_\_\_\_

I acknowledge that data to be released MAY INCLUDE material that is protected by Federal law and that is applicable to specific health statuses, drug / alcohol usage and mental health information. I also understand that once my medical records leave this practice, there is a potential for re-disclosure by the recipient if they are no longer protected by the Privacy Rule.

My signature authorizes release of all such information (as specified above and for the purpose mentioned above).

\_\_\_\_\_  
 Patient Signature or Legal Representative      Date      Relationship, if not patient

\_\_\_\_\_  
 Signature of Witness      Date

**Right to Revoke:** I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire one (1) year after the date on which it was signed. To revoke, I understand I must contact the following in writing: Gastrointestinal Specialists of Georgia, 711 Canton Rd NE Suite 300, Marietta GA 30060.