

Patient: _____ Date of Birth: _____ SS#: _____

Gastroenterology and Hepatology Specialists, Inc.
4360 Fulton Dr., N.W. Suite B
Canton, Ohio 44718
Fax #: 330-305-9090

Patient Authorization to Use or Disclose Protected Health Information

This authorization permits _____ to send the protected health information ONLY to
Organization/Doctor Name: _____
Address: _____
Phone #: _____ Fax #: _____

I, _____, understand _____ is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose this information, and the recipient(s) of that information. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand and I retain the right to revoke this authorization.

Description of the information to be used or disclosed (check all that apply):

Medical Data/Information as related to:

- The patient's entire medical record.
(Note: This requires an explanation why the entire record may be disclosed)
 Specific condition(s): _____
 Specific professional service(s): _____
 Specific medication(s): _____
 Other: _____

Purpose(s) of the disclosure:

Insurance Change

New Insurance Company

This authorization is to be used for our own use, and Gastroenterology and Hepatology Specialists, Inc. and affiliates will not condition treatment or payment on this authorization. Moreover, the patient has the right to receive a copy of the information to be used or disclosed and may refuse to sign this authorization. A fee may be assessed for copies requested.

This authorization for release of information is valid for 60 days from the date of signature, unless revoked by a written notice to the providing institution, providing said notice is received prior to release of the information.

If you wish to revoke this authorization, please refer to the Notice of Information Practices.

Responsible Party's Signature

Date

Refusal to provide your signature will result in the non-release of protected health information.