Patient Authorization to Use or Disclose Protected Health Information

I, ______________________________, SSN____________________ D.O.B.__________,
Understand Mobile Gastroenterology 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 the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of Mobile Gastroenterology, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. 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 that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Please *INITIAL* below to indicate your understanding.

________ I understand the information in my health record may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

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

____ The patient's entire medical record
Explanation____

____ The patient's demographic information (check all that apply))
___ Name ___ Address ___ State/Zip Code ___ Telephone/Cellular
___ Age ___Gender ___Race ___ other ______________

____Medial Data/Information as related to:
____Specific condition(s):____
____Specific professional service(s):__________________________________
____Specific medications(s):____

____ Other ____
____

The identified information may be used by or released to the following individual(s) or organizations(s):

Name: ______________________________
Address/Phone: ______________________
____
____

Name: __________________________
Address/Phone: _________________
____
____

Name(s) or class of person(s) authorized by this form who may use and disclose the patient's protected health information:

Mobile Gastroenterology
6701 Airport Blvd. Suite A-208
Mobile, AL 36608
P (251)639-2101
F (251)639-9122

(If you have more than ten (10) pages to send, please mail to above address)

Purpose(s) of the information:

_____Continuation of care with other health care providers
_____My Personal records
_____Other (please describe) ____

I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment

This authorization will expire on _______________. If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

______________________________ ______________
Patient Signature Date

If not signed by patient, please indicate relationship to patient

Relationship: _____________________
Witnessed by: _____________________

Alabama Code Section 12-21-6.1 allows Mobile Gastroenterology to bill for the release of medical records