ADULT GASTROENTEROLOGY ASSOCIATES

*an affiliate of* GI Alliance

## Limited Patient Authorization for Disclosure of Protected Health Information

**Form 7.31**

Please print all information. Form must be signed and dated each year.

**Patient Name:** _____

**SSN (last four digits):** _____ **Date of Birth:** _____

**Entity Requested to Release Information:**

**GI Alliance**

**Purpose of request (who will be authorized to receive information)** - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

**Who will be authorized to receive information** (list the individual/entity who is to receive your PHI):

Individual/Entity Name: _____

Address: _____

Phone: _____

**Description of information to be disclosed** - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays;
- ☐ financial history report (previous 3 years only).
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: _____

**Purpose of disclosure** (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

patient or representative signature — date

_____ _____

patient or representative signature — date

_____ _____

patient or representative signature — date

_____ _____

patient or representative signature — date

You have the right to receive a copy of signed authorizations upon request.

**Patient Instructions for Form 7.31**

**Limited Patient Authorization for Disclosure of Protected Health Information**

The Limited Patient Authorization will give our office the authority to provide the person or entity you designate on the form with access to your protected health information (PHI). The Limited Patient Authorization is limited to accessing only the information that you designate and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your health information to a person or entity that may be involved in your healthcare.

The following outline will describe the information we will need on the form and its purpose. Please address any questions you have with our staff.

**Patient Name** - Print your name.

**Social Security Number and Date of Birth** - This information is needed for identity verification and will be maintained in a confidential manner at all times.

**Entity Requested to Release information** - This simply identifies who is to provide the information.

**Purpose of Request-** To disclose your protected health information to an individual.

**Who will be authorized to receive information** – Enter the name, address and phone number of the individual or entity that you are designating to receive the disclosure.

**Description of Information to be disclosed** - The type and amount of health information that we disclose is determined by you. We can disclose or provide access to all of your health information, or it can be limited to a specific item.

**Purpose of Disclosure** - Regulations require that we identify the purpose for disclosing limited information. You also have the right to keep the purpose to yourself by selecting "Patient Request."

**Expiration or Termination** - This authorization will expire at the end of the calendar year in which it was signed unless you specify an earlier termination. The authorization must be renewed each year as a means of protecting your information by verifying your wish to continue the authorization for disclosure.

**Right to Revoke or Terminate -** You may revoke or terminate the authorization at any time by submitting written notice to our Privacy Manager.

**Non-Conditioning Statement** - This simply states that our practice does not place conditions for treatment on the use of the authorization.

**Redisclosure Statement** - We cannot be responsible for what the receiving entity does with your health information that we provide under this authorization. The redisclosure statement simply informs you of this situation.

**Signature and Date** - We will need your signature and date of the signature to make the authorization effective.

**Copies** - We will provide you with a copy of this signed authorization upon request.

 