Limited Patient Authorization for Disclosure of Protected Health Information To an Individual **Form 7.31**

Please print all information. Form must be signed and dated each year, see page 2.

Patient Name: _____

Social Security Number: _____ **Date of Birth:** _____

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

Who will provide or disclose information:

Practice Name: Gastroenterology Specialists, Inc.

Provider: _____

Address: 2726 Fulton Dr. NW

City: Canton State: OH Zip: 44718

Phone: 330-455-5011

Who will be authorized to receive information (list each family member, friend, or other individual to receive PHI)**:**

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

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

_____

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

☐ Patient Request

☐ Other (please specify): _____

Expirations or termination of authorization: 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. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list date of expiration if earlier than end of calendar year): _____

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. You may revoke an authorization at any time, in writing, except to the extent that your Healthcare Provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: 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 will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

_____ _____

patient signature date

_____ _____

patient signature date

_____ _____

patient signature date

_____ _____

patient signature date

_____ _____

patient signature date

_____ _____

patient signature date

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