PHONE 920-738-7300 FAX 920-738-7301

AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

Photocopy or facsimile of the original authorization will be considered as valid as the original

Patient: **DOB:**
Address:

INFORMATION TO BE RELEASED FROM: **INFORMATION TO BE RELEASED TO:**

Associates in Gastroenterology	
Name of Health Care Provider	**Name of Receiver**
820 E Grant St, Suite 230	
Street Address	**Street Address**
Appleton, WI 54911	
City/State/Zip	**City/State/Zip**

INFROMATION TO BE RELEASED INCLUDES:

X	Records	Dates	Specify Types	X	Records	Dates	Specify Types
	Clinic Visit				**Alcohol & Drug Abuse**		
	Consultation				**Mental Health**		
	Discharge Summary						
	Doctors Orders/Progress Notes				**Fit for Work Reports**		
	ER Reports						
	History & Physical				**Cardiac Cath**		
	Immunizations				**HIV testing**		
	Occupational Health				**Lab Reports**		
	Operative Reports				**Xray/Imaging Reports**		
	Rehab Clinic				**EKG**		
	Therapy Notes-PT/OT/Speech				**OTHER: (Specify)**		

NEED FOR THE DISCLOSURE:

X	Reason	X	Reason
	Changing Providers/Relocation/Moving		**Application for Insurance**
	Consultation/Further Medical Care		**Court Case**
	Disability Determination		**Legal Investigation**
	Personal		**Payment Process/Insurance/Billing**
	Vocational Rehab Evaluation		**Other (Specify):**
	Worker's Comp Injury		

IF ACTING as a personal representative of the patient, please state purpose of how you are acting on the behalf of the Patient:

I understand that if the person(s) and/or organization listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand that I have the right to inspect or copy the health information I have authorized to be disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department.

I understand that I have the right to refuse to sign this authorization and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

I understand that I have the right to withdraw this authorization - written notification is necessary to cancel this authorization. To obtain information on how to withdraw My authorization or receive a copy of my withdrawal, I may contact the health information department. I am aware that my withdrawal will not be effective to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the following date(s)_____ or for one (1) year from the date signed. I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REP:_____ **DATE:**_____

RELATIONSHIP:_____ AUTHORITY TO SIGN REASON:_____

(If signed by patient representative, state relationship and authority in which to sign for the patient, e.g. Deceased, minor, incompetent)

Req filled by: _____ Date:_____Recs Released_____

(Employee)