Dr. Saracino Gastroenterology P.C.
Authorization for Use/Release of Health Information

(This form applies only to the release and disclosure of information. It is not consent for treatment or intended for any other purposes.)

Name_____ Chart #_____

By signing this form, I authorize Dr. Saracino Gastroenterology, P.C. to use, release or disclose the protected health information described below to:

Name of Person and/or Organization to Whom Information Should be sent: **Dr. Saracino Gastroenterology P.C.**
Address of Person/Organization to Whom Information Should be sent: **PO Box 1578**
Kinston, NC 28503-1578

Please send this information on or about (information will not be resent without another authorization): ____/____/____
This authorization expires upon fulfillment of request unless special circumstances noted below ** Mo Day Year

Purpose of disclosure (at request of patient, employment, life or disability insurance, etc.): _____

I authorize the following information to be sent to the address above:

___ Copies of all medical records for the period ___/___/____ to ___/___/____

___ Copies of the information described below for period ___/___/____ to ___/___/____

___ Complete Medical Record	___ Consultations	___ History & Physical Examination
___ Office Visit Notes	___ Treatment Plan	___ HIV/AIDS
___ Reports from Other Physicians	___ Discharge Summary	
___ Procedure Reports	___ Lab, X-ray, etc. Reports	

___ Other (Please Specify)_____

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should *not* be released, even if occurring during dates above:_____
_____
_____

I understand that there may be information in these records that I would **not** want released.

I have been provided a copy of **Dr. Saracino Gastroenterology P.C.** *Notice of Privacy Practices* and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, disclosure of my health information with **Dr. Joseph Saracino,** Privacy Officer or other appropriate office personnel.

I understand that **Dr. Saracino Gastroenterology P.C.** assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release **Dr. Saracino Gastroenterology P.C.** from all legal liability that may arise from this authorization.

Patient's Signature _____ **Date** _____

SS# _____ DOB:_____

Address_____

If the signature above is not that of the patient, I am acting for the patient because _____

My relationship to the patient is: _____. Signed _____

The patient or their representative may revoke this authorization by notifying in writing **Dr. Saracino,** designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to redisclosure by the recipient.