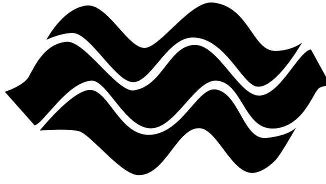

Anne Arundel Gastroenterology Associates, P.A.

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ____________________, authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization.

❑ Endoscopy Reports
❑ Colonoscopy Reports
❑ Upper Endoscopy
Please specify dates____________________

❑ Medical Office Notes
Please specify dates____________________

❑ Medical Records
Please specify dates ________

❑ Lab Reports, please specify
❑ Other, please specify

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information for the following reasons:

____

____

____

3. I authorize the following persons (or class of persons) to receive my protected health information:

Name: ____

Address: ____

City/State/Zip: ____

Relationship: ____

Reason for Release: ____

4. I understand that I have the right to revoke this authorization at any time. My revocation must be in writing. The revocation notice must be sent in writing to the Privacy Officer, AAGA, Bestgate Medical Clinic, 820 Bestgate Road, Suite 2A, Annapolis, MD 21401. This authorization does not expire unless we receive the revocation notice in writing.

5. This authorization may only be revoked as noted in #4, above.

6. I understand that this is a voluntary form and that I do not have to grant authorization of access to the protected health information if I so choose. I also understand that this will not affect my eligibility for health benefits through my insurance carrier.

7. I understand that I have the right to inspect my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R.164.524).

8. I certify that I have received a copy of this authorization.

____________________________________ ____________________________
Patient's Name/Person Authorizing Date

____________________________________ ____________________________
Accepted by Signature Date

____
Printed Name of Person Receiving Authorization