Authorization to Release Medical Records to Third Party

I hereby authorize _____ d/b/a GI Alliance on behalf of itself and all other practices that are operation as a single HIPAA affiliated Covered Entity (collectively "Provider") to transfer, release, or obtain information on:

_____ (Name of Patient) _____ (Date of Birth) _____ (Last 4 Digits of SSN)

OBTAIN FROM: (DO NOT LEAVE BLANK)	DISCLOSE TO: (DO NOT LEAVE BLANK)
☐ Provider: _____	_____ Individual/Name of Entity
☐ All GI Alliance (select if seen by multiple providers)	_____ Address
_____ Address	_____ City, State, and Zip
_____ City, State, and Zip	_____ Phone
_____ Phone	_____ Fax
	Delivery Method: ☐ E-Delivery ☐ Mail

For the Purpose of:

- ☐ Continuing Medical Care
- ☐ Insurance
- ☐ School
- ☐ Military
- ☐ Legal Purposes
- ☐ Social Security/Disability
- ☐ Patient's Request
- ☐ Other (specify)

Date(s) of Treatment: ☐ Specific Dates: _____ thru _____ ☐ All Dates

Please Check Specific Information Request

- ☐ All Records
- ☐ Abstract Record*
- ☐ Medication Records
- ☐ Laboratory/Pathology Reports
- ☐ Radiology Reports
- ☐ Verbal Communication Only
- ☐ Office/Progress Notes
- ☐ Operative Notes
- ☐ Itemized Billing Statements
- ☐ Other (Specify) _____

I understand that my records may contain but are not limited to: history, diagnosis, and/or treatment of sexually transmitted diseases, drug and/or alcohol abuse, mental illness, psychiatric treatment, or genetic counseling. By initialing, I give my specific authorization for these records to be released:

- ☐ ____ HIV/AIDs
- ☐ ____ Drug/Alcohol Use
- ☐ ____ Genetic Testing
- ☐ ____ Mental Health/Developmental Disabilities

**(Office notes, procedures, images, and test results only)*

This authorization will be effective for **one (1) year** from the date signed below or the date on which Patient no longer receives services from Provider, whichever is later. I have the right to revoke this authorization at any time by notifying Provider at _____, _____, __ ____; Attn: Privacy Officer. My revocation must be in writing. My revocation will not be effective to the extent Provider has already relied upon this authorization (by using or disclosing information).

Signing this form is optional. Provider will not condition Patient's treatment or payment for care on whether I sign this form. Once information is disclosed as a result of this form, it may no longer be protected by the federal HIPAA privacy rules. I may obtain a copy of this form by contacting the Privacy Officer at the address listed above.

_____ _____

(Signature of Patient or Parent/Representative) (Date)

_____ _____

(Print) (Phone)

_____

(Relationship to Patient)