

Patient Instructions for Patient Authorization for Release/Disclosure of PHI

The Patient Authorization will give our office the authority to provide the person you designate on the form with access to your protected health information (PHI). The Patient Authorization is limited to accessing only the information that you designate and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your health information to persons or entities that may be involved in your healthcare (i.e., family members or friends).

Failure to complete this form properly will delay the processing of your request.

Records requests will be processed in a timely manner and no longer than 30 days after the date of the request is received by Charleston Gastroenterology Specialists.

The following outline will describe the information we need on the form and its purpose. Please address any questions you have with our staff.

Patient Name — Print your name.

Date of Birth — This information is needed for identity verification and will be maintained in a confidential manner at all times.

Purpose of Request

Entity Providing Information — Print the name of our practice or, if you are requesting another healthcare provider to send information to us, the name of that healthcare provider. This simply identifies who will provide the information.

Entity Receiving the Information — Print the name and contact information of the person you want to receive or have access to your health information. If you are requesting that another healthcare provider send your health information to us, you would list the name and contact information of our practice.

Description of Information to be Disclosed — The type and amount of health information that we disclose is determined by you. We can disclose or provide access to all of your health information, or it can be limited to specific information that you list on the form.

Purpose of Disclosure — Regulations require that we identify the purpose for disclosing limited information (see choices on the form). You also have the right to keep the purpose to yourself by selecting “Patient Request”.

Expiration or Termination — This authorization will expire one year from the date of your signature unless you specify an earlier termination.

Right to Revoke or Terminate — You may revoke or terminate this authorization at any time by contacting our Privacy Manager. Requests for revocation or termination must be made in writing.

Non-Conditioning Statement — This simply states that our practice does not place conditions for treatment on the use of this statement.

Redisclosure Statement — We cannot be responsible for what the receiving entities does with your health information that we provide under this authorization. The redisclosure statement simply informs you of this situation.

Signature and Date — We will need your signature and date of the signature to make the authorization effective.

Copies — We will provide you with a copy of the signed authorization upon request.

**CHARLESTON GASTROENTEROLOGY SPECIALISTS
CHARLESTON ENDOSCOPY CENTER**

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Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated. Instructions are available at the patient's request.

Patient Name: _____ Date of Birth: _____

I authorize Charleston Gastroenterology Specialists to disclose /
release information to:

Practice/Provider: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

I authorize Charleston Gastroenterology Specialists to obtain
information from:

Practice/Provider: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

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, including but not limited to: office notes; lab results; x-rays; hospital, and other physician records; record of HIV and communicable disease testing; record of mental health or substance abuse treatment.
- Only send the following: _____

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

Continued care.

Patient Request

Other (please specify): _____

Expirations or termination of authorization: This authorization will expire one year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization.

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.

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, once 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

Personal Representative

Relationship

Date

Copies of the signed authorizations are available upon request.