Bay Area Houston
Gastroenterology Associates

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Board Certified in Gastroenterology

AUTHORIZATION FORM
For Release of Protected Health Information

Patient Name

Address

Date of Birth Phone Number

By signing this form, I authorize the below stated physician to use and disclose the protected health information to or from below stated healthcare provider. The reason for this disclosure is necessary for continuity of care. My medical records may include information regarding diagnosis and treatment indicated in these records and this information released may include:

Discharge Summary	Laboratory Reports	Radiology Reports	History and Physical
Consultation Notes	Progress Notes	Operative Reports	Pathology Reports
Physician Orders	Entire Records		

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the said practice Joslyn Andrade, Privacy Officer for Bay Area Houston Gastroenterology Assoc., P.A.

I understand that a revocation is not effective to the extent that the practice has relied on this authorization and was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest acclaim under the policy or the policy itself.

I understand that information used to disclose pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal HIPAA Privacy Regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

Patient Signature, Legal Guardian or Legal Rep. Date Fax #

Release Records From:_____

Release Records To:_____