WACO GASTROENTEROLOGY ASSOCIATES, PA
364 Richland West Circle, Suite A Waco TX 76712
Phone: (254) 537-0911 Fax: (254) 537-0313

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ **Date of Birth:** _____

Release information from: _____

Release information to: _____
(include address and/or fax #) _____

For the purpose of: _____ Continued Care _____ Insurance _____ Worker's Comp.
_____ Personal use _____ Attorney/Legal _____ Disability/SSI
_____ Other (please explain): _____

Please release the following:
_____ Office visit notes/reports _____ X-Ray/Imaging reports from (date) _____ to (date) _____
_____ Endoscopy procedure reports _____ Laboratory results from (date) _____ to (date) _____
_____ Pathology reports _____ Other (specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
_____ Yes, I consent to the release of this information. _____ No, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time by presenting a written request to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization and will not apply to my insurance company when the law allows my insurance access to my information. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
If I do not specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and need not sign in order to ensure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure. If I have questions about the disclosure of my health information, I can contact a representative of the individual or organization above.

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and am hereby advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information in these entries. I will not hold Waco Gastroenterology Associates, PA liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to patient (if Legal Representative) Witness

Office Use Only:
Charges $ _____, paid cash-credit-check; received by: _____
Date request completed: _____ Initial: _____