WACO
GASTROENTEROLOGY
ASSOCIATES

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 records of:

Patient Name: ____ **Date of Birth:** _______________

Release of Information from Waco Gastroenterology Associates, PA

Release of Information to: ________________________________

Address and Fax Number: ________________________________

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 (date) _____ to (date)_______
____	Endoscopy reports	____	Laboratory results (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 or drug abuse.
____ Yes, I consent to the release of this info. ____ No, I do not consent to the release of this info.

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

I understand that I have the right to revoke this authorization at any time by presenting a written request to the individual or organization releasing the info. 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 6 months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the 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. I f have questions about the disclosure of my health information, I can contact a representative or the individual or the 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 herby advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained 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 CC Check _______ Rec'd By: __________

Date Request completed: __________ Initial: _______

Revised 5/17