AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

____________________	____________________
Name of Patient/Previous Names	Birth Date/Medical Record Number
____________________	____________________
Street Address	City, State, Zip

INFORMATION RELEASED FROM:

Tri-State Gastroenterology Associates
425 CentreView Blvd.
Crestview Hills, Ky. 41017

INFORMATION RECEIVED BY:

TO: ____________________
Name
____
Street Address
____
City, State, Zip Code

INFORMATION TO BE RELEASED:

Dates of treatment: ____________________
(if no date is indicated most current will be released)

___ Office Consults/Follow-up Reports
___ Procedure Reports
___ Hospital Reports
___ Laboratory Reports
___ Radiology Reports
___ Entire Record (Designated Record Set to include procedures, office consults/follow-ups, labs, radiology)
___ Other (specify):____________________

In compliance with Ky. Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

___ Mental Health
___ Developmental Disabilities
___ Alcoholism
___ HIV (AIDS)
___ Sexually Transmitted Disease
___ Drug Abuse
___ Other (Specify):____________________

For the Following Date(s): ____________________

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

___ Further Medical Care
___ Legal Investigation or Action
___ Personal
___ Insurance Eligibility/Benefits
___ Changing Physicians
___ Other (Specify): ____________________

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Privacy Office of Tri-State Gastroenterology Associates. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: the Privacy Officer for Tri-State Gastroenterology Associates. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the following date(s) ____________or for 90 Days from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP: ____________________ DATE: ____________
(If signed by other than patient, state relationship and authority to do so.)

WITNESS: ____________________

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