

**Birmingham Gastroenterology Associates  
Authorization to Disclose Protected Health Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical Record Number or SSN: \_\_\_\_\_

The following person or entity is authorized to disclose my medical records:

Birmingham Gastroenterology Associates  
1 Independence Plaza  
Suite 900  
Birmingham, AL 35209

The disclosure will be made to the following person or entity:

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For the purpose of:**

At the request of the patient,

OR: \_\_\_\_\_

**The type and amount of information to be used or disclosed:**

- Problem list
- Medication list
- List of Allergies
- Immunization Record
- Most Recent History and Physical
- Most Recent Discharge Summary
- Psychotherapy Records                      From (date) \_\_\_\_\_ to (date) \_\_\_\_\_
- Laboratory Results                              From (date) \_\_\_\_\_ to (date) \_\_\_\_\_
- X-Ray and Imaging Reports                      From (date) \_\_\_\_\_ to (date) \_\_\_\_\_
- Consultation Reports                              From (Doctor's Name(s)) \_\_\_\_\_
- Entire Records

Other \_\_\_\_\_

**I hereby authorize the use or disclosure of information about the above named individual and I understand that:**

1. This information about me is protected under federal law.
2. I may refuse to sign the authorization.
3. I have the right to revoke this authorization in writing.
4. Any revocation will be effective only to the extent that action has not been taken in reliance of my prior authorization.
5. Unless I revoke this authorization, it will expire on the following date \_\_\_\_/\_\_\_\_/\_\_\_\_, event or condition: \_\_\_\_\_ . If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
6. By signing below, I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.
7. Treatment or payment will not be based on my signing this authorization.
8. I will receive a copy of this authorization.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Personal Representative to the Patient

\_\_\_\_\_  
Signature of Witness