Birmingham Gastroenterology Associates
Authorization to Disclose Protected Health Information
205-271-8000 – 205-879-7061

Patient Name: _____ Date of Birth_____

Medical Record Number or SSN: _____

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

From: _____

_____

_____

Please route records to:

- *J. Lynn Cochran, MD*
- *P. David Miller, MD*
- *Mark R. Janich, MD*
- *H. Craig Philpot, MD*
- *J. Cotton Shallcross, MD*
- *Kenneth M. Sigman, MD*
- *Charles S. Bluhm, MD*
- *Owen R. McLean, MD*
- *David J. Landy, MD*
- *Christopher P. Shaver, MD*
- *Rajat Parikh, MD*
- *Rishi K. Agarwal, MD*
- *Charles A. Dasher, Jr., MD*
- *Katie Plourd, CRNP*
- *Emily Patton, CRNP*
- *Stevie Stewart, PA*

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

To: Birmingham Gastroenterology Associates
1 Independence Plaza, Suite 900
Birmingham, Al. 35209

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**
- **Laboratory Reports**
- **X-Ray and Imaging Reports**
- **Consultation Reports**
- **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**