AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION
Birmingham Gastroenterology Associates; Phone: 205-271-8000; Fax: 205-879-7061; www.bgapc.com

Patient Name:_____ **Date of Birth:** _____
Last **First** **Middle**

SSN/MR#: _____

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct my health care provider, ***Birmingham Gastroenterology Associates*** (physician, and/or administrative and clerical staff) to both:

RELEASE TO and/or **RECEIVE FROM**: (Name of entity receiving/releasing my health information:)

Address_____

City ST, Zip _____

Phone # & Fax # _____

my health information during the Term of this Authorization to the recipient that I have identified below.

Purpose: I understand that the specific purpose of this Authorization is _____
(Note: "at the request of the patient" is sufficient if initiated by patient)

Information to be disclosed: This authorization permits the above provider to disclose the following medical records:

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, physical condition and any treatment received by me, ***excluding*** HIV, STDs, drug/alcohol abuse or treatment and psychological/psychiatric, mental health, and psychotherapy notes.
- ☐ I grant ***special authorization*** for all of my health information described above ***including*** HIV, STDs, drug/alcohol abuse or treatment and psychological/psychiatric, mental health information, and psychotherapy notes.
- ☐ Only the following records or types of health information: (Dates of treatment, types of treatment or other)

_____

Term of Authorization: Remains in effect for 90 days or until the end of litigation (if not specified below):

- ☐ From the date of this Authorization until the _____ day of _____, _____
- ☐ Until the Provider fulfills this request.
- ☐ Does not expire or until the following: _____

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party who may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the continuation or quality of my treatment by my health care provider.

Revocation: I understand that this Authorization remains in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Officer at the address listed below. The revocation will be effective immediately upon receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____ _____ _____
Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Name of Guardian/Representative Legal Relationship Date Witness