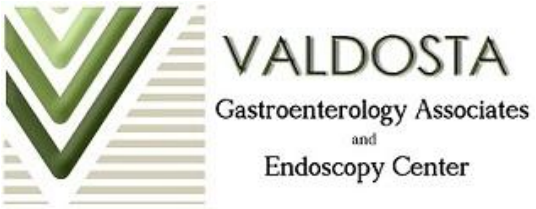

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HIPAA AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information (PHI)

I hereby authorize Valdosta Gastroenterology Associates (VGA) and/or Valdosta Endoscopy Center (VEC) to ☐ **Release** ☐ **Receive** information from the medical records of:

Patient: _____ SSN: _____-_____-_____
(Print Last Name, First Name, Middle Initial)

Address: _____ City:_____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Phone: (_____) _____-_____

Information to be: ☐ Sent To ☐ Received From

Name: _____ Phone: (___ __) _____-_____

Address: _____ City:_____ State: _____ Zip: _____

(If information is to be released to VGA or VEC, please use fax numbers above).

For dates of service rendered from: ____/ ____/_____ through ____/ ____/_____

Information to be released:
☐ Any and all medical records ☐ Other _____

This disclosure is being made for the following purpose(s): (Check all that apply)

☐ Continuing Care
☐ Attorney / Court Case
☐ Worker's Compensation Case
☐ Other
☐ Transfer of Care / Referral Physician
☐ Insurance
☐ Personal Reasons

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VALDOSTA
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and
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HIPAA AUTHORIZATION FORM (Continued)
Authorization for Use or Disclosure of Protected Health Information (PHI)

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. (Federal Law prohibits the re-disclosure of the above information without written consent of the patient or authorized representative).

I understand that I have the right to revoke this authorization at any time by presenting a written revocation to the Medical Records or designee. I understand that the revocation will not apply to any information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the rights to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date below.

I understand that authorizing the disclosure of this health information is voluntary, and that I need not sign this form in order to assure treatment.

I understand that any disclosure of the information has the potential for an unauthorized re-disclosure and that the re-disclosure may not be protected by federal confidentiality rules.

Date: _____ Name of Requestor: _____
(Patient or Authorized Person)

Signature: _____

Relation to Patient: _____ (If other than Patient)

Witness: _____