

Authorization to Share Health Information

I, _____, allow my physician(s), my health plan or insurers, and any other healthcare providers to give medical information relating to my treatment and/or condition.

This information can include spoken, written facts about my health or payment benefits that I may have. It can include copies of my records from healthcare providers or health plans about my health or care.

Allied Gastrointestinal Associates will use and release this information only for treatment or payment for any and all services that they may render. Allied Gastrointestinal Associates can also give this information to others as long as we remove any information that would identify you.

I know that people that work for and with Allied Gastrointestinal Associates may use and see my information, but they may only use it as allowed on this form. I understand that Allied Gastrointestinal Associates will keep my information private, but if it is accidentally given out, federal laws will not protect it.

This authorization will last seven (7) years after the date that I sign it. If at any time I change my mind and want to nullify this authorization, I will notify my health care providers and/or my insurer in writing that I do not want them to share any further information with outside entities. If I inform them to stop in writing, it will not change any actions they took before I informed them.

I am well aware that I do not have to sign this form. My choice about whether or not I sign this form will not alter the medical care or the way this practice treats me. I know that I am aware that I have the right to see or obtain a copy of the information that the practice is sending to other providers and/or insurers.

I understand that it is my responsibility to obtain payment from my insurance company and that I am ultimately responsible for the costs of my care.

I agree that a copy of this form may be treated as a signed original.

Patient Sign Here _____ Date _____