Philadelphia Gastroenterology Consultants, Ltd.

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ____ DOB: ____________________

I hereby authorize the use or disclosure as appropriate of my individually identifiable health information-including any medical records regarding my treatment, hepatitis C, drug abuse, alcoholism or human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS) or testing for HIV by Philadelphia Gastroenterology Consultants, Ltd. To:

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Purpose for the use of disclosure:

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The patient or patient's representative must read and <u>initial each of the following statements</u>:

_____ I understand that this authorization is voluntary and my treatment is not conditioned on my signing this authorization.

_____ I understand that if the entity listed to receive this information is not a health plan or healthcare provider, the information released may no longer be protected by federal privacy regulations.

_____ I understand that the authorization may be revoked by me in writing as explained in Philadelphia Gastroenterology Consultants, Ltd.'s Notice of Privacy Practices, but the revocation won't have any effect on uses or disclosures prior to the revocation.

_____ I understand that I will receive a copy of this authorization.

____ ____________________

Signature of Patient or Patient's representative **Date**

Printed Name of Representative: ____

Authority to act for Patient: ____

Form must be complete prior to signing. You may refuse to sign this Authorization.

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