AUTHORIZATION FOR RELEASE OF PRIVATE HEALTH INFORMATION

Date_____

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name_____ ID Number_____

Address_____ Signature_____

_____ Date_____

Phone_____

I hereby authorize the following person to obtain private medical information regarding my condition and/or health matters on my behalf, by either telephone, computer correspondence or in person from my physician or staff at Miami Gastroenterology Consultants, P.A.

Name_____ Relationship to Patient_____

Address_____

_____

Phone_____

This authorization is valid for a period of one year as of the date it is authorized by the patient, if during this time the patient wishes to change the aforementioned information, a written request must be submitted to our office to properly execute any changes to this authorization