Authorization to Release Health Information

I, _____, hereby authorize _____
to disclose health information regarding the following patient:

Patient Name: _____ Date of Birth: _____

Address: _____ Patient's Phone: _____

_____ Patient's SS#: _____

The purpose of this release is for medical treatment only at the request of the patient.
The information is to be disclosed to the following person or organization:

Gi Specialist of Clarksville, PC
Anil Patel, MD PC
280 Warfield Blvd., Clarksville, TN 37043
(931) 551-9605
(931) 614-7521 fax

Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around _____ or include all dates of service.

The following medical records:

- ❑ Endoscopy report and biopsy report
- ❑ History and Physical
- ❑ Consultation report
- ❑ Progress Notes
- ❑ Summary of treatment
- ❑ Lab work results
- ❑ X-ray reports
- ❑ Operative report
- ❑ Discharge summary
- ❑ Alcohol and Drug Treatment Reports
- ❑ Entire Medical Record
- ❑ Photographs, Videos, or other images
- ❑ Other: _____

Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the Center. However, the revocation will not have any effect on any uses or disclosures the Center may have made before the revocation was received.

Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the date this authorization is signed.

Re-disclosure. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be re-disclosed by the receiving party.

Refusal to Sign. I understand that I may refuse to sign this Authorization and that the Center will not condition treatment on whether I sign this Authorization.

Certification. I certify that I am:

- ❑ The patient, and the identification that I have, provided is true and correct.
- ❑ The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of _____.

Signature: _____ Signed this _____ day of _____, 20_____.

Witness: _____ Print Name: _____ Date: _____

For Office Use Only:
Date Received: _____ Expiration Date: _____ Release Faxed: _____
How was identity verified? _____ Copy made? _____
How was authority verified? _____ Copy Made? _____
By: _____Title: _____Date: _____