CHARLESTON GI

Charleston Gastroenterology Specialists
Charleston Endoscopy Center
Lowcountry Endoscopy Center
Summerville Endoscopy Center
843-722-8000

PATIENT AUTHORIZATION TO DISCLOSE OR OBTAIN PROTECTED HEALTH INFORMATION

Please print all information. Form must be signed and dated. Instructions are available at the patient's request.
Fax # 843-647-6066

Patient Name: _____ Date of Birth: _____

☐ I authorize Charleston GI to disclose/release information to:

Practice/Provider: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

☐ I authorize Charleston GI to obtain information from:

Practice/Provider: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

I authorize Charleston GI to discuss my healthcare treatment with:

☐ Spouse (name)_____ ☐ Family Member(s) (name) _____

☐ Friend (name) _____ ☐ Other (name) _____

Description of information to be disclosed: I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record, including but not limited to: office notes; lab results; x-rays; hospital, and other physician records record of HIV and communicable disease testing; record of mental health or substance abuse treatment.

☐ Only disclose the following: _____

☐ Billing and Financial: _____

Purpose of disclosure (please check the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Continued Care ☐ Financial:_____ ☐Other (please specify): _____

This authorization will expire one year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization.

As stated in our Notice of Privacy Practices, you have the right to terminate this authorization by submitting a written request to our Privacy Manager.

The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information, once disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

_____ _____
Patient or Representative Signature Date

_____ _____
Patient or Representative Signature Date

_____ _____
Patient or Representative Signature Date

Copies of signed authorizations are available upon request.