CHARLESTON GI

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

PATIENT INSTRUCTIONS FOR PATIENT AUTHORIZATION FOR RELEASE/DISCLOSURE OF PHI

The Patient Authorization will give our office the authority to provide the person you designate on the form with access to your protected health information (PHI). The Patient Authorization is limited to accessing only the information that you designated and does not give any other rights to the person you have named on the form. Us of this form will enable us to provide your health information to persons or entities that may be involved with your healthcare (i.e., family members or friends).

Failure to complete this form properly will delay the processing of your request.

Records requests will be processed in a timely manner and no longer than 30 days after the date of the request is received by Charleston Gastroenterology Specialists.

The following outline will describe the information we need on the form and its purpose. Please address any questions you have with our staff.

Patient Name – Print your name.

Date of Birth – This information is needed for identity verification and will be maintained in a confidential manner at all times.

Purpose of Request

Entity Providing Information – Print the name of our practice, or, if you are requesting another healthcare provider to send information to us, the name of that healthcare provider. This simply identifies who will provide the information.

Entity Receiving Information – Print the name and contact information of the person you want to receive or have access to your health information. If you are requesting that another healthcare provider send your health information to us, you would list the name and contact information of our practice.

Description of Information to be Disclosed – The type and amount of health information that we disclose is determined by you. We can disclose or provide access to all of your health information, or it can be limited to specific information that you list on the form.

Purpose of Disclosure – Regulations require that we identify the purpose for disclosing limited information (see choices on the form.) You also have the right to keep the purpose to yourself by selecting “Patient Request”.

Expiration or Termination – This authorization will expire one year from the date of your signature unless you specify an earlier termination.

Right to Revoke or Terminate – You may revoke or terminate this authorization at any time by contacting our Privacy Manager. Requests for revocation or termination must be made in writing.

Non-Conditioning Statement – This simply states that our practice does not place conditions for treatment on the use of this statement.

Redisclosure Statement – We cannot be responsible for what the receiving entities does with your health information that we provide under this authorization. The redisclosure statement simply informs you of this situation.

Signature and Date – We will need your signature and date of the signature to make the authorization effective.

Copies – We will provide you with a copy of the signed authorization upon request.