

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

This authorization gives Regional Gastroenterology Associates of Lancaster, Ltd.(RGAL) permission to disclose health information about you:

Right to revoke. You may revoke this authorization at any time except to the extent that we have relied on the authorization. To revoke this authorization, you must submit a written revocation to our privacy officer at the following address:

RGAL
Attn: Privacy Officer
2104 Harrisburg Pike Ste. 300
PO Box 3200
Lancaster, PA 17604-3200

Re-disclosure. Health information disclosed pursuant to this authorization may be subject to re-disclosure and may be no longer protected by the federal privacy rule or another privacy law, or by this authorization.

PLEASE PRINT ALL INFORMATION EXCEPT SIGNATURE

1. Patient Name: _____ Date of Birth: _____

2. Covered health information (describe in a specific and meaningful fashion)

All health information related to treatment

3. Authorized action: disclosure

4. Identity of recipient (Provide the name or other specific identification of the person(s) or class of persons to whom RGAL may disclose the covered information.)

5. Each purpose of the authorized disclosure.*

At the request of individual

*“At the request of individual” is sufficient for uses and disclosures initiated by the patient who does not, or elects not to, provide a statement of the purpose.

(OVER)

6. Expiration of authorization (Provide a date or event that relates to the patient or the purpose of the use and/or disclosure.)

When authorization is revoked in writing.

7. You may may not (circle one) disclose protected health information which includes confidential psychiatric information, drug and alcohol information and HIV-related information.

I have read and understand this authorization and disclosure of health information about the named patient as described in this authorization. I acknowledge receipt of a copy of this authorization.

Signature of patient
(or patient's personal representative)

Date of receipt

Personal representative information (if applicable):

Name of personal representative

Relationship to patient (or other authority)