GASTRO HEALTH

www.gastrohealth.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities, as that term is defined by HIPAA must obtain a signed authorization from the individual or the individual's legally authorized representative to disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Individuals cannot be denied treatment based on a failure to sign this authorization form.

NAME OF PATIENT OR INDIVIDUAL

_____

Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month_____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____)_____ **ALT. PHONE** (____)_____

EMAIL ADDRESS (Optional):_____

I AUTHORIZE GASTRO HEALTH AND ITS SUBSIDIARIES AND AFFILIATES TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION? May we disclose your protected health information to your: spouse, adult children, siblings, attorney, Life Insurance Company or other entity? If yes, Please write their name, contact information and relationship to you.

Person/Organization Name _____

Relationship _____

Address _____

City _____ State _____ Zip Code _____

Phone (____) _____ Fax (____) _____

REASON FOR DISCLOSURE

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All Health Information**
- ☐ History/Physical Exam
- ☐ Past/Present Medications
- ☐ Lab Results
- ☐ Physician's Orders
- ☐ Patient Allergies
- ☐ Operative Reports
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Diagnostic Test Reports
- ☐ Pathology Reports
- ☐ Billing Information
- ☐ Radiology Reports
- ☐ Imaging Films
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (Excluding psychotherapy notes)

_____ Drug, Alcohol, or Substance Abuse Records

_____ Genetic Information (Including Genetic Test Results)

_____ HIV/AIDS Test Results/Treatment

HOW CAN WE COMMUNICATE WITH YOU? Please list the telephone number and/or e-mail address where we can speak to you about your appointments or results.

_____

_____

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):

Month____**Day**____**Year**_____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected. If I revoke this Authorization, I must send a written request to: **GASTRO HEALTH, LLC 9500 S. Dadeland Blvd. Suite 200, Miami, FL 33156 ATTN: Privacy Officer**. I understand that the revocation will not apply to information that has already been released in reliance on this Authorization and to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

RESEARCH: I understand that if treatment being provided is related to research for which I have consented to, then my authorization of disclosures for research related purposes is a condition of said treatment. I understand that if I do not sign this authorization, then the Provider will not provide research-related treatment to me.

SIGNATURE AUTHORIZATION: I have read this form and agree to the use and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____

Signature of Individual or Individual's Legally Authorized Representative DATE

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ☐ Parent of Minor ☐ Guardian ☐ Other_____

SIGNATURE X _____ _____

Signature of Minor Individual DATE

Delivery Method: ☐ Mail ☐ Pickup Date:_____ **Format Requested**: ☐ Paper ☐ CD (Only for Imaging)

Records will automatically be mailed 10 days after pick-up date. (Initial) _____

Charges: In accordance with F.S. 395.3025 licensed Healthcare facilities and ambulatory surgery centers, the fee for medical record copy is: $1.00 search fee for every year requested: $1.00 per page for paper records; $2.00 per page for non-paper records, plus sales tax and actual postage. In accordance with F.S. 456.057 and F.A.C. 64B8-10.003, Healthcare practitioners and physicians' offices charge for medical record copy is: $1.00 per page for the first 25 pages and .25 cents for any page after that. Reasonable costs of reproducing x-rays and such other special kinds of records shall be the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication.

Informed of charge for copies (Please initial) _____

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CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby consent to the use or disclosure of my protected health information by Gastro Health, LLC (the "Provider") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Provider. I understand that diagnosis or treatment of me by the Provider may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Provider is not required to agree to the restrictions that may request. However, if the provider agrees to a restriction that I request, the restriction is binding on the provider and all physicians associated with the Provider.

I have the right to revoke this consent, in writing, at any time, except to the extent the Provider has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider a healthcare plan, my employer or a health care clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies, or there is a reasonable basis to believe the information may identity me.

I understand I have a right to review the Provider's Notice of Privacy Practices prior to signing this document. The Provider's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Provider. The Notice of Privacy Practices for the Provider is also provided in the waiting room. This Notice of Privacy Practices also describes my rights and the Provider's duties with respect to my protected health information.

The Provider and all physicians associated with the Provider reserve the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Name of Patient or Personal Representative | Description of Personal Representative's Authority

DOCUMENTATION OF GOOD FAITH EFFORTS

Patient Name _____ Date _____

The patient presented for treatment on this date and was provided with a copy of the Provider's Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement of the receipt of the notice. However, an acknowledgement was not obtained because:

☐ Patient refused to sign.
☐ Patient was unable to sign or initial because:

_____

☐ There was a medical emergency (the Provider will attempt to obtain acknowledgement at the next available opportunity).
☐ Other reason, described below:

_____

_____

Signature of employee completing form:

x _____ Name: _____