AUTHORIZATION FOR RELEASE OF PATIENT IDENTIFIABLE HEALTH INFORMATION

Date of Request_______________________ Account Number _______________________

I hereby authorize The Endoscopy Center at Robinwood to release to:

____

(Doctor, Hospital, Attorney, Insurance Company, self, etc.)

____

Address Phone Number

The following information from the medical records of:

____

Patient's Name Date of Birth Social Security Number

SPECIFIC INFORMATION TO BE RELEASED:

_______ Entire Record _________History & Physical: Summary: Operative Report: Consultations

_______ Test Results (specify) _____________ _________ Other (specify)_______________________

_______ Limitations (specify) ____

THIS INFORMATION IS NEEDED FOR:

_______ Personal Use ________ Continuing Medical Care ______ School _______ Insurance ______ Military

_______ Legal Reasons ________ Social Security/Disability ______ Other _______________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about history, diagnoses and/or treatment of drug or alcohol abuse, mental illness, or communicable disease. I authorize the disclosure of this specific information. I also understand that the person giving authorization by a written and dated notice to the Medical Information Management department may revoke this authorization. I understand that the revocation will not apply to my insurance company when the law provided my insurer with the right to contest a claim under my policy. This authorization expires one year from the date of signature, unless I specify otherwise or revoke it. I understand that I may be charged for copies of my health information.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.

I understand authorizing the use or disclosure of the health information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_______________________________ _______________________________

Signature of Patient Date Signature of Parent/Executor/Legal Representative Date

_______________________________ _______________________________

Witness Date Witness Date

Revised March 2005

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