GLST
Gastrointestinal & Liver Specialists of Tidewater,PLLC

Colonial Gastroenterology Associates
Office: 757-534-7701 Fax: 757-534-7708

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.
I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. I understand if my record contains information related to substance abuse, HIV and/or mental health, the information will be released with my medical record.

Patient Name: _____

Date of Birth: _____ Last 4 digits of SS#: _____ Account #: _____

Person/Organizations providing information:

_____
_____
_____

Persons/Organizations receiving information:

_____
_____
_____

Information to be disclosed, covering the period of health care: From_____ To_____
☐ Complete health record **OR, select from the following:**
☐ Office notes ☐ Pathology reports ☐ Procedure reports ☐ Laboratory Tests
☐ X-ray reports ☐ Other (please specify) _____

This information is to be disclosed for the purpose of: Continuity of Care
The patient or the patient's representative must read and initial the following statements:

a. I understand that unless earlier revoked, this authorization will expire **5 years** from the date signed below. **Initials:** _____
b. I understand that I may revoke this authorization at any time by notifying **GLST** in writing. If I do it won't have any effect on any actions **GLST** took before it received the revocation. **Initials:** _____
c. I understand that **GLST** cannot make me sign this authorization as a condition to receive treatment from GLST except:
   (i) when GLST provides me with research-related treatment; or
   (ii) when GLST provides me with health care solely for the purpose of creating protected health information for disclosure to someone else. **Initials:** _____

Gastrointestinal and Liver Specialists of Tidewater, PLLC, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Please be aware there may be a charge for obtaining your records.

_____
Signature of Patient or Representative Date

_____
Print Name Relationship of Representative to Patient