5839 Harbour View Blvd., Suite 200, Suffolk VA 23435 - Phone (757) 483-6100, Fax (757) 483-2203

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. ***YOU MAY REFUSE TO SIGN THIS AUTHORIZATION***

Patient Name: ____

Date of Birth: ____________________________ Last 4 digits of SS#: ______________________

Person/Organizations providing information:
Gastrointestinal & Liver Specialists of Tidewater, PLLC (GLST)
5839 Harbour View Blvd, Suite 200
Suffolk, Virginia 23435 Fax (757) 483-2203

Persons/Organizations receiving information:
____
____
____

Information to be disclosed, covering the period of health care: From__________________ To__________________
☐ Complete health record
OR, select from the following (check as many as apply & please provide dates):
☐ Office notes ____
☐ Pathology reports ____
☐ Procedure reports ____
☐ Laboratory Tests ____
☐ X-ray reports ____
☐ Other (please specify) ____

This information is to be disclosed for the purpose of: ____

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 **one year** 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.

____ __________________
Signature of Patient or Representative Date

__________________________________ __________________________________
Print Name Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the patient: ______________________________