SHAREDID-10

Gastroenterology Associates - Privacy Information

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Patient Name: _____ Date of Birth: _____

Phone: _____

Privacy Information for patients:

Your medical record in this office is protected confidential information. It may be shared or disclosed with other medical providers re: diagnosis and treatment, providing insurance information or health care operations. Any other use requires your permission. You may decide who can receive the information. By signing below you acknowledge that a Notification of Privacy Practices has been made available, and a copy available if requested. You give permission for us to use this information and it can be revoked in writing only. Please contact the office manager if you have any questions.

I agree that Gastroenterology Associates may request and use my prescription medication history from other healthcare providiers or third-party pharmacy benefit payors for treatment purposes.

I hereby authorize Gastroenterology Associates to release any and all information contained in my record to all insurance companies that is relative to claims made on my behalf and also that said payments be made directly to Gastroenterology Associates. This also applies to Medicare payments under the Social Security Act and Medicare and its intermediary carriers. This authorization remains valid during my lifetime or until otherwise revoked in writing by myself.

NAME _____ DOB: _____

Address _____

Patient Signature _____ Date: _____

Witness _____ Date: _____

Sharing of Medical Information: I hereby give authorization to share Protected Health Information to the following, if they request it on an urgent basis. It includes, identifying information, health coverage information, past, present and future claims information and medical records. This authorization is voluntary. They may not be subject to comply with Federal Health Information Privacy Laws. Please spend time and fill out the name of a person you are giving us permission to share your medical information.

I give my permission for Gastroenterology Associates to request or release my medical records.

Name _____ Relationship _____

Name _____ Relationship _____

This authorization will expire _____ or lifetime (Circle).

Patient Signature _____ Date: _____

Witness _____ Date: _____