AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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Facilities
Center for Digestive Health
Lake Country Endoscopy Center
Mayfair Digestive Health Center
Moreland Endoscopy Center
The Surgery Center
Wisconsin Digestive Health Center

PLEASE PRINT

I, _____, *(Date of Birth)* _____ do hereby consent and authorize *(Name of Physician)* _____ to disclose to *(Name)* _____ at, *(Address)* _____, *(City, State, Zip)* _____ information from my medical records relating to my identity, diagnosis, prognosis, or treatment compiled during my medical treatment(s) from *(Date)* _____ to *(Date)* _____.

Type or extent of medical information to be disclosed:

___Medical History and Physical
___Operation Reports
___Treatment or Tests
___ X-ray reports
___All Other Reports
___Laboratory Tests
___Prescriptions
___Consultations
___Hospital Records with All Reports

Disclosures requiring special consent:

___HIV/AIDS Test Results
___Mental Health Records
___Alcohol, Drug Abuse Records

The purpose or need of this disclosure is:

___Personal
___Medical
___Other _____
___Legal Investigation
___Payment of Insurance Claim

I understand that the specific type of information to be disclosed includes all reports that are part of my medical history, with exception of disclosures requiring special consent, and that this information may be transmitted by facsimile (Fax). I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to GI Associates, LLC. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. This authorization for disclosure will be effective until *(Date)* _____ or six months from the date signed.

_____ Signature of Patient OR

_____ Date

_____ Person Authorized by Patient

_____ Relationship to Patient

Note to Recipient of Information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, law may prohibit you from making any further disclosure of this information without the specified written consent of the patient or legal representative involved.

NOTE: Person authorized by the patient means the parent, guardian, or legal custodian of a minor patient or a patient adjudged incompetent; the spouse or personal representative of a deceased patient or any person authorized in writing by the patient is witnessed and dated.

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