VALLEYCARE GASTROENTEROLOGY MEDICAL GROUP, INC.
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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION

______________________________ ______________ ______________
Name of Patient *Date of Birth* *Telephone Number*

I AUTHORIZE: ______________________________
(Records/PHI being sent from)

TO DISCLOSE TO: ______________________________
(Records/PHI being sent to)

____
FAX NUMBER *TELEPHONE NUMBER*

FOR THE PURPOSE OF: ______________________________

TYPE/FORM: Paper: Mail / Fax (30 copies or less) Electronic: CD or: online health account

REVOCATION: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt.

REDISCLOSURE: I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION CARRIES WITH IT THE POTENTIAL FOR AN UNAUTHORIZED REDISCLOSURE AND THE INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES (unless the information is protected by 42U.SC. Sec 290dd-2 for alcohol/drug abuse records).

SELECT RECORDS:
__________Medical Records Specify other records to be disclosed: ______________

I authorize the release of information in my health record which may include information relating to:
( ) sexually transmitted disease
( ) behavioral or mental health services
( ) acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)
( ) treatment for alcohol and drug abuse which is protected by virtue of the provisions of Federal Regulations 42 CFR, part2.

I understand, signing this form, that I am confirming my AUTHORIZATION for use and/or disclosure of the protected health information described in this form with the recipient named in this form. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45CFR164.524.

Expiration of this authorization (please initial one of the following)

__________ 90 days after signing **__________ On this date:____________**

______________________________ ______________
SIGNATURE DATE