MID STATE GASTROENTEROLOGY LLC
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AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

Patient Name ___________________________ *Date of Birth*_______________________

Address: _______________________________ *City*______________________________

State: _________________ *Zip Code:* _________*Phone:* ( )______________________

I hereby authorize Mid State Gastroenterology, LLC to disclose
( ) or request( ) my health information

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( ) Endoscopies ( ) Labs ( ) Consultations ( ) Progress Notes

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I understand that I have the right to revoke this aurthorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in six months.

I understand that any disclosure of informaton my be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may inspect and/or copy the information to be disclosed, and that authorizing this disclosure in voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may included information pertaining to the treatment of drug and alcohol abuse, mental illness, hepatitis, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) , sexually transmitted diseases, tuberculosis or genetics. This information will be released unless you indicate otherwise.

____ ___________________ *Signature of*
Patient or Authorized Representative *Date*