Sierra Nevada Gastroenterology Medical Associates, Inc.

Authorization for Release of Information

Section A: Must be completed for ALL authorizations

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:

Patient Name: _____

Date of Birth: _____ **MR Number:** _____

Organization providing the information	**Organization receiving the information**
_____	_____
_____	_____
_____	_____
_____	_____

Specific description of the information (including date(s) of healthcare to be disclosed and why:

_____

_____

Section B: Must be completed for All authorizations:

The patient or the patient's representative (who is legally authorized) must read and initial the following statements:

1. I understand that this authorization will expire on _____/_____/_____
   Initials: _____

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation.

_____ _____

Signature of patient or patient's representative **Date**

Printed name/Relationship of patient's representative:_____

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

This form may not be used to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.