Riverdale Gastroenterology & Liver Diseases

www.riverdalegastro.com

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Michael S. Ader, M.D. ◆ David F. Stein, M.D., F.A.C.P., F.A.C.G., A.G.A.F.
Jeremy M. Gutwein, M.D., M.S.

AUTHORIZATION FORM FOR PATIENT RECORDS RELEASE

Section A: Must be completed for all authorizations

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. Any health information disclosed pursuant to this authorization may be subject to redisclosure by the recipients and may no longer be protected by the Federal privacy regulations.

Patient name:_____ ID Number (if applicable): _____

(Who has the medical records)
Persons/organizations authorized to use or disclose my information: _____

(Who are we sending records to)
Persons/organizations who may receive my information: _____

Specific description of the information to be used or disclosed (including date(s)): _____

Description of each purpose of the use or disclosure of my health information: (Note: If the release of information is requested by the patient, please insert "at the request of the patient" here if the patient does not provide a statement of purpose.) _____

For marketing authorizations only: If this authorization will allow the use of patient information for marketing purposes, please indicate whether the marketing involves any direct or indirect remuneration from a third party to the Practice:

_____

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Section B: The patient or the patient's representative must read and initial the following statements

1. I understand that this authorization will expire on _____ Initials_____
   [Insert Expiration Date or Event]

2. I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form. Initials_____

3. I understand that I will get a copy of this form after I sign it. Initials_____

4. I understand that I may revoke this authorization at any time by notifying the Practice in writing, but if I do, the revocation will not have any effect on actions the Practice has already taken in reliance on this authorization. Initials_____

_____ _____
Signature of patient or patient's representative **Date**
(Note: *This form MUST be completed before signing*.)

If this authorization is signed by a patient's representative, please complete the following:

_____
Printed name of patient's representative:

_____
Relationship to the patient:

Describe the representative's authority to act for the patient:
_____
_____
_____

* YOU MAY REFUSE TO SIGN THIS AUTHORIZATION *