411 Westwood Dr.
Wausau, WI 54401
P#:715-847-2558 F#: 715-847-2557

RELEASE OF INFORMATION (ROI)

AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION (PHI)

Name – Last, First, MI		Previous Name/Nicknames	
Street Address	City	State	Zip
Date of Birth	Contact Number		

I AUTHORIZE THE FOLLOWING ORGANIZATION TO DISCLOSE MY PHI TO GI ASSOCIATES:

Organization:	Phone #	Fax #
Address	City	State

GI ASSOCIATES IS AUTHORIZED TO DISCLOSE MY PHI TO:

Name of Person/Organization:	Phone #	Fax #
Address	City	State

TYPE OF INFORMATION TO BE RELEASED

☐ **GI ASSOCIATES RECORDS** (Information dictated/ordered by GastroIntestinal Associates providers only)
☐ **OFFICE VISITS** ☐ **PROCEDURE/PATH**
☐ **RADIOLOGY REPORTS** ☐ **LAB RESULTS** ☐ **GROWTH CHART**
☐ **OTHER (PLEASE SPECIFY)** ____

Purpose or need for disclosure:
☐ **Further medical treatment**
☐ **Other (please specify)** ____
☐ **Patient use** **Information may be released electronically: (Please check which apply)**
☐ **Email address (please provide):** ________________________**(NOT recommended by GIA, email is not encrypted)**
☐ **Flash drive (this method is not encrypted)**

My signature below confirms I understand: I have the right to a copy of this authorization. I may revoke this authorization at any time by written notice to the organization I authorized to use or disclose my information, but if I do so it will not impact any use of disclosure that has taken place before the revocation. Treatment, payment, enrollment in a health plan or eligibility for benefits cannot be conditioned on my decision whether to sign this authorization except for certain research-related treatment, or if the purpose of this authorization is to create information for a third party (such as an independent medical examination), or in connection with an insurance dispute if this authorization is a condition to obtain insurance coverage. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.

This authorization is valid for one (1) year from date of signing unless earlier date indicated: _____/_____/20_____.

I authorize the use and/or disclosure of my medical information in accordance with the conditions listed above. I understand there may be charges for copies, in accordance with state law.

Signature of Patient ____ **Date** ____________________________

If signed by person other than patient, state relationship and authority to do so.

Relationship: ____

Patient is: ☐ **Minor** ☐ **Incompetent/Incapacitated** ☐ **Deceased**

Legal Authority: ☐ **Legal Guardian** ☐ **Parent of Minor** ☐ **Spouse of Deceased** ☐ **Health Care Agent** _________

12/2020 ☐ **Personal Representative/Domestic Partner of Deceased** **Other** ______________________

EMERGENCY CONTACTS

(Disclosure Authorization)

Patient Name:____DOB _____________ ________

Email Address: ____

Please list the family members, close friends, or other people who we can notify regarding your care or with who we can discuss your protected health information. **Protected health information consists of test results, diagnoses, billing information, insurance information and treatment options.** This form will be effective until you provide further notice to us.

Emergency Contact:
(If patient is a minor, this must be a parent or guardian)

Name:____ Relationship to patient: ____________________

Primary Phone:___________________ Home Cell Work (circle one) Secondary Phone:___________________ Home Cell Work (circle one)

Others:

Name:____ Relationship to patient: ____________________

Primary Phone:___________________ Home Cell Work (circle one) Secondary Phone:___________________ Home Cell Work (circle one)

Name:____ Relationship to patient: ____________________

Primary Phone:___________________ Home Cell Work (circle one) Secondary Phone:___________________ Home Cell Work (circle one)

Name:____ Relationship to patient: ____________________

Primary Phone:___________________ Home Cell Work (circle one) Secondary Phone:___________________ Home Cell Work (circle one)

Patient Signature

I acknowledge my protected health information can be released to the people I have listed above. I have the right to revoke this form at any time in writing at the office listed above.

Patient / Authorized Representative Signature: ____

Date: ______________________________

Please retain this form in the patient's medical record.