GI ASSOCIATES

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

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, as 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** _____
☐ **Personal Representative/Domestic Partner of Deceased** ☐ **Other** _____