

TRIANGLE GASTROENTEROLOGY
2600 Atlantic Avenue, #100
Raleigh, NC 27604

Patient Name

Address

Home Phone

Date of Birth

City, State and Zip

Social Security Number

The type and amount of information to be used or disclosed is as follows: Dates of Service _____ to _____

- | | |
|--|---|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> ED Record | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Psychiatric and/or Substance Abuse |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Other _____ |

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

I hereby authorize Triangle Gastroenterology to release my medical information to:

Facility

Address

City, State and Zip

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Triangle Gastroenterology. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 1 (one) year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.534. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the manager of Triangle Gastroenterology at 919-881-9999.

Signature of Patient or Legal Representative

Date

Witness

Date