www.RockyMountainGastro.com

ROCKY MOUNTAIN
GASTROENTEROLOGY

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Medical Records Release and HIPAA Authorization Form

HIPAA Privacy Regulations require that health care organizations provide patients with the ability to access, review, and copy their protected health information (PHI).

For the purpose of this form, a medical record is defined as any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for RMG**.** This includes medical and billing records, or any other material containing PHI and used by RMG to make decisions about patients.

Patient Name: ___________________________________ Date of Birth: ___________________

Address: __________________________________ City/State/Zip: _______________________

The above listed patient authorizes Rocky Mountain Gastroenterology to make record disclosure to:

Facility or Provider Name: ___________________________ Fax/ Phone: ___________________

Address: __________________________________ City/State/Zip: _______________________

Effective Period:

a) This authorization for release of information covers the period of healthcare from: ______________________ to ________________________

b) All past and present periods.

Restrictions: only medical records originated through RMG will be copied. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my PHI may include data relating to sexually transmitted diseases, AIDS or HIV. It may also include information about mental health services and treatment of alcohol and drug abuse.

I understand I may revoke this authorization in writing at any time. I understand that a revocation does not apply to information already released. I also understand that this 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 on the following date, event or condition: ______________________. If I fail to indicate an expiration date, event or condition this authorization will expire one year from the date signed.

I understand that authorizing the disclosure of this health information is strictly voluntary. I can refuse to sign and I need not sign it to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure of my PHI and the information may not be protected by federal confidentiality rules.

I have read the above authorization for Release of Information and do acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X ____ ____

Signature of Patient/Guardian or Authorized Representative   Printed Name of Authorized Representative

Date of Request: ___________________________