

# **AUTHORIZATION TO OBTAIN HEALTH INFORMATION**

**PATIENT:**

\_\_\_\_\_  
Name of Patient/Previous Names

\_\_\_\_\_  
Birth Date/Medical Record Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

**INFORMATION RELEASED FROM:**

**INFORMATION RECIEVED BY:**

\_\_\_\_\_  
Name of Health Care Provider/Plan/Other

Tri-State Gastroenterology Associates

\_\_\_\_\_  
Street Address

425 Centre View Blvd.

\_\_\_\_\_  
City, State, Zip Code

Crestview Hills, Ky. 41017

**INFORMATION TO BE RELEASED:**

For the Following Date(s): \_\_\_\_\_

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Medical History, Examination, Reports | <input type="checkbox"/> Surgical Reports                   | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Treatment or Tests                    | <input type="checkbox"/> Hospital Records Including Reports | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> Allergy Records                       | <input type="checkbox"/> Laboratory Reports                 | <input type="checkbox"/> Prescriptions |
| <input type="checkbox"/> Consultations                         | <input type="checkbox"/> Entire Record                      |  |
| <input type="checkbox"/> Other (Specify): _____                |   |  |

In compliance with Ky. Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> Mental Health          | <input type="checkbox"/> Developmental Disabilities   | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> HIV (AIDS)             | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Other (Specify): _____ |   |                                     |

**PURPOSE FOR NEED OF DISCLOSURE:** (Check applicable categories)

- |   |  |                                   |
|---|--|-----------------------------------|
| <input type="checkbox"/> Further Medical Care           | <input type="checkbox"/> Legal Investigation or Action | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Insurance Eligibility/Benefits | <input type="checkbox"/> Changing Physicians           |                                   |
| <input type="checkbox"/> Other (Specify): _____         |  |                                   |

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:**

**Right to Inspect or Copy the Health Information to Be Used or Disclosed** - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Privacy Office of Tri-State Gastroenterology Associates. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: the Privacy Officer for Tri-State Gastroenterology Associates. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

**EXPIRATION DATE:** This authorization is good until the following date(s) \_\_\_\_\_ or for 90 Days from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

**SIGNATURE PATIENT/LEGAL REP:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
*(If signed by other than patient, state relationship and authority to do so.)*

**WITNESS:** \_\_\_\_\_