



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 _____

8/2016 Personal Representative/Domestic Partner of Deceased Other _____