GATEWAY GASTROENTEROLOGY, INC
OFFICE: (314) 529-4900
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION, GATEWAY GASTROENTEROLOGY, INC

Patient's Full Name (print): _____ Former Name (if applicable): _____

Date of Birth: _____ Phone: _____ Fax: _____ SSN: _____

I, or my personal representative, hereby authorize Gateway Gastroenterology, Inc. to use or disclose protected health information (PHI) regarding my care and treatment. I understand that:

1. PHI relating to **ALCOHOL/DRUG ABUSE, MENTAL HEALTH, GENETIC TESTING, HIV/AIDS** and/or communicable diseases may be included in records and I authorize disclosure of such PHI. As applicable, I specifically authorize release of certain treatment or conditions by placing my initials in the appropriate space(s) in Item 8(b).
2. Information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state law. If I am authorizing the disclosure of HIV/AIDS information, the recipient is prohibited from re-disclosing the information without my authorization, unless permitted to do so under state or federal law. I have a right to request a list of people who may receive or use my HIV/AIDS information without authorization.
3. I have the right to revoke this authorization at any time by providing a written notice of revocation to the provider at the address listed in Item 5 below, except to the extent Signature has already relied upon this authorization.
4. Signing this authorization is voluntary. Gateway Gastroenterology, Inc. may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.

5. Provider Releasing This Information (one provider per form)

Name: _____

Address: _____ Phone: _____ Fax: _____

6. Purpose for Release of Information

☐ At My Request ☐ Continuity of Care ☐ Other _____

7. Person(s) to Receive This Information

Name: _____

Address: _____ Phone: _____ Fax: _____

☐ I Will Pick Up ☐ My personal representative _____ will pick up (identification required for pick up).

Note: Requests may be subject to payment for copying/mailing fees and request may be processed by a Gateway business associate.

8(a). Description of Information Being Released

Date(s) of service (required, list all dates): _____

I would (choose one): ☐ My Entire Medical Record ☐ An Abstract (pertinent information related to the above listed date(s))

☐ X-Ray/MRI/Other Radiology (specify) _____ ☐ Other _____

8(b). Include Information Relating to (initial besides each appropriate category):

____ Alcohol/Drug Treatment ____ Mental Health Treatment

____ Genetic Testing Information ____ HIV/AIDS ____ Psycotherapy Notes (complete a separate authorization form for these notes)

9. Date or Event on Which This Authorization Will End:

☐ One-Time Request ☐ Specific Event or Date: _____

10. Signature (by signing below, I acknowledge that I have read and agree with all the above)

Signature: _____ Date: _____

Print the Name of Person Representative if Signing for Patient and Specify Authority: _____

☐ Parent ☐ Guardian ☐ Health Care Agent ☐ Administrator/Executor ☐ Other _____