GASTROINTESTINAL HEALTHCARE
Improving Your Health From The Inside Out.
2011 Falls Valley Drive, Suite 106, Raleigh, NC 27615
Phone: 919-870-1311 Fax: 919-881-0822
www.giraleigh.com

HIPAA FORM

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

****Can we leave your medical information on your voice mail? • Yes • No**

****Name of patient's pharmacy: _____**

**** Name of patient's emergency contact: _____Relationship to patient:_____**

Emergency contact's phone number: _____ HIPAA Approved? • Yes • No

I acknowledge that a copy of the Patient Rights and Patient Responsibilities Policy and Privacy Policies Notice,
in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are posted visibly in the facility, and are available at www.giraleigh.com. A paper copy will be provided upon request.

Please be advised that without your *written authorization* we cannot discuss your case, treatment, or your pre – and post-procedure care instructions with *anyone* other than yourself. We need specific *written authorization* from you in order to be able to do so. Please indicate below with whom we may discuss your healthcare.

I hereby authorize GastroIntestinal Healthcare (GIH) to furnish all necessary information to appropriate parties such as insurance carriers, physicians, and attorneys concerning treatments rendered.

Medical records may be disclosed to the following Physicians:

_____

_____

Please list any additional parties (e.g. spouse, children, significant other, or person responsible for providing care to you) to whom information, such as post-operative instructions, may be disclosed by GIH:

_____
Name of Person(s) (Family member or Friend) and/or Organization

If you would like to authorize someone other than yourself for GIH to speak with regarding your medical bills/financial responsibility, please provide authorization for us to speak to them regarding your account.

_____
Name of Person(s) (Family member or Friend) and/or Organization

Expiration date of authorization: This authorization is effective for one year from the date signed unless revoked or terminated by the patient or patient's representative.

Right to terminate or revoke authorization: You may revoke or terminate this authorization by submitting a written revocation to GastroIntestinal Healthcare. You should contact the Privacy/Compliance Officer to terminate this authorization.

Potential for re-disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under Federal Privacy Regulations.

Patient Name (please print): _____ Date of Birth: _____

Patient Signature: _____ Date of Signature: _____

Signature of Patient Representative:_____ Relationship: _____