NOVA INNOVATIVE GASTROENTEROLOGY, PLCC

AUTHORIZATION TO DISCLOSE (RELEASE) PROTECTED HEALTH INFORMATION (PHI)

Please Print
Patient's Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____
E-Mail Address: _____
Date(s) of Service: _____

Purpose of Release: □ Continuity of Care/ Treatment □ Leaving Practice/Change of Doctor □ Self/Personal Reasons □ Disability □ Insurance □ Employment Related □ Research □ Legal Reasons

I hereby authorize the release of my health information from NOVA Innovative Gastroenterology, PLLC to:
Person/Physician Practice/Organization Authorized to Receive Information:
Name: _____
Address: _____
Phone #: _____ Fax #: _____
Email:_____

Information to be Released – Specify the content to be released in the area below:
□ Complete Record
□ Minimum Documents (dates of record to release)_____

Method of Release: □ Mail □ Fax □
Email:_____

Revocation: I understand that I may revoke this authorization, in writing, at any time except to the extent that NOVA Innovative Gastroenterology, PLLC has relied on this authorization to release protected health information. Revocation must be made in writing and submitted to NOVA Innovative Gastroenterology, PLLC. Redisclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Fees: The fee will depend on the number of copies requested and the current rate allowed by state law. NOVA Innovative Gastroenterology, PLLC does not condition treatment, payment enrollment or eligibility for benefits on the signing of this authorization.

Signature of Patient: _____
Date Signature: _____

or Patient's Legal Representative Relationship signature:
_____

Please include a copy of the document authorizing your authority to act on behalf of the patient (e.g. health care power of attorney).