Consultants In Gastroenterology, P.C.

PATIENT INFORMATION RELEASE AUTHORIZATION

To avoid delay in receiving requested information, complete ALL sections. All sections must be completed in order for the authorization to be accepted.

Name of Facility: Consultants In Gastroenterology, P.C.

Address of Facility: 1730 S. 70th Street, Suite 110, Lincoln, NE 68506

Patient Name:_____ DOB: _____

Address: _____ Phone #:_____

E-mail Address:_____

WHO: (check one)

☐ Provide a copy of My **Health Record to** me.

☐ Release **My Health Record to**: _____

Physician Name and Practice

_____

Physician Address Phone # Fax #

WHAT: (check one or more)

☐ Most Recent Office Visit _____

Diagnostic Test/Results: ☐ Lab ☐ Radiology Report ☐ Pathology ☐ Colonoscopy/EGD/Flex Procedure Report

☐ History & Physical done by CIG providers

☐ Date(s) of service: _____ to _____*insert date(s) of service requested*

☐ Other: _____

☐ Complete record

This Authorization does NOT include records from other healthcare providers that are a part of my Consultants In Gastroenterology records.

WHY: (check one)

The purpose and need for such disclosure:

☐ Per patient request ☐ For my healthcare / treatment ☐ For legal purposes ☐ For payment / insurance purposes

☐ Other: _____

FORMAT: (check one)

I request that the copy be provided:

☐ Mailed ☐ Certified mail (additional fee will apply)

☐ Faxed

☐ Patient pick-up

It is strongly recommended that your health record be provided via fax.

If there is a charge associated with your records release the fees are: **$20 handling fee plus .50¢ per page (pre-payment required)**

I understand that:

- That CIG will not condition my treatment on whether I provide authorization for the requested use or disclosure.
- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid for 60 days from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here:_____
- I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to CIG where my Authorization was made or given.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.
- I understand there may be a fee for a copy of My Health Information as defined previously. I understand that all fees will be in compliance with applicable law. I agree to pay this fee.

_____ _____

Signature of Patient *Date*

If you are NOT the patient but are signing on behalf of the patient, please complete below: You **must** attach proof of your authority to act on behalf of the patient as checked if other than parent.

☐ Parent with parental rights

☐ Court Appointed Guardian

☐ Medical Power of Attorney

☐ Other_____

_____ _____

Representative Signature *Date*

All sections of this form must be completed in order for the authorization to be accepted.

Copies will be sent within 30 days of receipt of the completed authorization form.

This form is valid for sixty (60) days from the date of signing.

For questions, please call the Medical Records Department at 402-441-5600.

Physician Approval: _____ Date: _____

Released By: _____ Date: _____