Midwest Gastrointestinal Associates, PC

Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Social Security Number: ___-___-___ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize the use and disclosure of individually identifiable health information related to me, otherwise known as "Protected Health Information" or "PHI" under a federal privacy law, as described below. I understand this authorization is voluntary. I consider a copy of this authorization to be valid as the original. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Person(s)/organization(s) providing the information: _____

_____

Name and address of person(s)/organization(s) receiving the information: _____

_____

Specific description of information to be released including date(s) and types(s) of service: _____

_____

_____

Purpose for which information is to be used:

☐ Treatment ☐ Insurance ☐ Personal ☐ Follow-Up ☐ Legal

☐ Other (specify):_____

Method of Delivery:

☐ Fax – Fax Number: _____

☐ Secure Email – Email Address: _____

☐ U. S. Postal Service (To be delivered to Address Above)

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to *(please initial appropriate box below)* and hereby release Midwest Gastrointestinal Associates, PC from all legal liability that might arise from the release of sensitive information protected by Title 42 of the Code of Federal Regulations.

____ Substance Abuse (alcohol or drug abuse)

____ Behavioral Health (except psychotherapy notes which require a specific authorization)

____ HIV or other Sexually Transmitted Disease-Related Information (or AIDS related testing)

Complete information on reverse.

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Conditions. We may not condition your right to receive health care services from us upon your signing this authorization. However, if the treatment to be provided is for research purposes, your failure to sign this authorization will prevent us from providing such treatment.

Further Uses and Disclosures. When we use or disclose your health information to other parties as you have instructed in this authorization, we will not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such a situation, your disclosed health information may no longer be protected by federal and state privacy laws.

Revocation. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it, by writing to:

Midwest Gastrointestinal Associates, PC
Attn: Privacy Officer

8901 Indian Hills Drive, Suite 200
Omaha, NE 68114
Office: (402) 397-7057
Fax: (402) 397-6656

17001 Lakeside Hills Plaza, Suite 200
Omaha, NE 68130
Office: (402) 855-8700
Fax: (402) 885-8719

808 East Pierce Street, Suite 301
Council Bluffs, IA 51503
Office: (712) 396-2997
Fax: (712) 796-1194

Without my written permission to revoke this authorization, it will automatically expire twelve (12) months from the date of signing according to Nebraska law. If a specific date (not to exceed twelve months) or event upon which this authorization will expire I will specify: _____

I understand that I am entitled to a copy of this authorization form. I understand that I have the right to inspect or receive copies of my Protected Health Information (PHI) to be used and/or disclosed under this authorization, and that a fee for copies may be imposed by Midwest Gastrointestinal Associates, PC or its designated Business Associate.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Printed Name of Patient's Legal Representative Relationship to Patient

FOR MGI USE ONLY:
MRN _____ Application Fee(s) _____
Date Received: _____ Date Copies Sent: _____
Other Considerations: _____
_____