Gastroenterology, Ltd.
Colon Cancer Prevention & Endoscopy Center of Virginia Beach
www.vbgastro.com
(757) 481-4817

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Authorization

I authorize Gastroenterology Ltd. **to release protected health information** via voice mail

☐ **Yes**

☐ **No**

Please check to the right, the description of information to be released

☐ Results of Lab tests/x-rays

☐ Financial

☐ Other_____

☐ Breach Notification

EMERGENCY CONTACT NAME, RELATIONSHIP, PHONE NUMBER

_____ _____ _____

☐ Financial

☐ Medical

If Necessary, may we discuss personal health information with this contact?

☐ **Yes** ☐ **No**

Please check to the right, the description of information to be released

EMERGENCY CONTACT NAME, RELATIONSHIP, PHONE NUMBER

_____ _____ _____

☐ Financial

☐ Medical

If Necessary, may we discuss personal health information with this contact?

☐ **Yes** ☐ **No**

Please check to the right, the description of information to be released

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

10/14, 03/15