______________________________________ ___________________________
Patient Name **Date of Birth**

______________________________________ ___________________________
Address **City, State and Zip**

______________________________________ ___________________________
Home Phone **Social Security Number**

The type and amount of information to be used or disclosed is as follows: Dates of Service _________ to _______

- ○ Entire Medical Record
- ○ Face Sheet
- ○ ED Record
- ○ Discharge Summary
- ○ History & Physical
- ○ Consultation
- ○ Operative Report
- ○ Laboratory
- ○ Psychiatric and/or Substance Abuse
- ○ Other ___________________________

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

I hereby authorize ___________________________________ to release my medical information for use in my medical care and treatment to:

Triangle Gastroenterology
2600 Atlantic Avenue, #100
Raleigh, NC 27604
919-881-9999 – Phone
919-881-9998 - Fax

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Triangle Gastroenterology. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 1 (one) year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.534. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the manager of Triangle Gastroenterology at 919-881-9999 or the company whom provided the above requested medical records.

______________________________________ ___________________________
Signature of Patient or Legal Representative **Date**

______________________________________ ___________________________
Witness **Date**