Austin Gastroenterology

Austin Endoscopy Center I, LP/Austin Endoscopy Center II, LP

Authorization for the Release of Protected Health Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Phone: _____
Street Address City/Zip
Social Security Number: _____ Alternate Phone #: _____

I, _____, hereby authorize the designated medical custodians or database custodians of Austin Gastroenterology, PA (AG); Austin Endoscopy Center I, LP (AEC I), and/or Austin Endoscopy Center II, LP (AEC II) to release/request my protected health information (PHI) as described below:

SEND RECORDS TO:
Name: _____
Address: _____
_____
Phone Number: _____
Fax Number: _____

OBTAIN RECORDS FROM:
Name: _____
Address: _____
_____
Phone Number: _____
Fax Number: _____

Description of records **to be used/disclosed** (i.e. "procedure reports", "laboratory/pathology reports", "ENTIRE RECORD", etc.). Please include date(s) of service or specify "ALL". _____
_____
(Note: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records, genetic testing or venereal disease, unless specifically requested above.)

This authorization shall be in force and effect until _____, at which time this authorization **to use or disclose** this protected health information expires. I have the right to revoke this authorization in writing, at any time, by sending such written notice to **Stephanie Combs or Designee, Privacy Officer, 9211 Waterford Centre Blvd., Suite 200, Austin, TX 78758.** A revocation is not effective to the extent that AG, AEC I and/or AEC II have relied on the use or disclosure of the PHI.

I agree to pay AG, AEC I, and/or AEC II for the cost of copying and mailing the said records. Such cost is calculated to be: $_____ ($25 for 1st 20 pages (postage included); $.50 per page over 20 pages; $6 for postage and handling; and $15 for notarized copy).

I understand and agree that:

- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- AG, AEC I, and/or AEC II will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility of benefits on whether I provide authorization for the requested use or disclosure.
- I am entitled to inspect and obtain a copy of my PHI maintained by AG, AEC I, and/or AEC II.
- I am required to make a written request for access to PHI using this form, which must be completed in order for AG, AEC I, and/or AEC II to provide the requested information.
- AG, AEC I, and/or AEC II have the right to charge me for copying and mailing costs.
- Per HIPAA guidelines, I have the right to request AG, AEC I, and/or AEC II to amend my PHI or record in the designated record set.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient's Representative (if applicable) Relationship to Patient (if applicable)