



Authorization Form Policy

Effective date of policy: September 1, 2013

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations (TPO) and as otherwise required by law. Examples of some instances in which we are required to disclose your PHI include:

Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker's Compensation.

Ironwood Gastroenterology, LLC will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

A patient may revoke his authorization to use or disclose PHI at any time but actions taken prior to the revocation are excluded. If authorization is a condition of obtaining insurance coverage, and the authorization is revoked, the insurer may contest a claim under the policy.

Authorizations must be properly executed by the patient or his personal representative. It should include, the date signed, specific PHI to be released or used, to whom this use or release relates, and an expiration date for the authorization.



Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ Complete Health Records

_____ Lab results/X-Ray Reports

_____ Physical Exam

_____ Consultation Reports

_____ Immunization Record

_____ Physical Exam

Other (please specify):

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

For the Purpose of: _____

6. I understand that I have a 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 the health information management department. 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 on the following date, event, or condition: _____
7. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. 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 to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact: _____

Privacy Officer for Ironwood Gastroenterology, LLC: _____

Signature of patient or legal representative

Signature of witness

Date: _____

Date: _____