DOB:__________________

AUTHORIZATION

Patient Name:____
Patient Identification Number: ___________________________________

I hereby authorize **ROCKFORD GASTROENTEROLOGY ASSOCIATES, LTD. (RGA)**, including its physicians, nurses, staff and other employees, to use and/or disclose my health information as described below:

Specific Description of the Information to be Used or Disclosed:
All test results, including lab, pathology and radiology (without limitation)
All diagnoses and follow-up treatment plans

Persons or Class of Persons to Whom the Use or Disclosure May be Made:
Husband, Wife, Son, Daughter, Power of Attorney
Other:____________________________________

The Information Will be Used and/or Disclosed for the Following Purposes:
(Note: If Authorization initiated by Patient, a statement that the Authorization is "at the request of the individual" is sufficient.)
At the request of the individual

This authorization expires ____
(indicate date, or an event relating to you personally or to the purpose of this Authorization)

I have read and understand the following statements about my rights:

- I understand that information disclosed pursuant to this Authorization might be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this Authorization at any time by notifying the Privacy Officer of **RGA** in writing. Notwithstanding the foregoing, I understand that I may not revoke this Authorization to the extent that **RGA** has taken action in reliance upon it.
- I understand that I may refuse to sign this Authorization and that my refusal to sign in no way affects my ability to receive treatment.

______________________________________ ____________________________
Signature of Patient or Patient's Representative Date

<u>For Patient Representatives</u>:

Printed Name: ____
Relationship to Patient: ____
Authority for Patient Representative Status: _____________________________________