HIPAA Authorization Form

I, _____ herby authorize Rockford Gastroenterology Associates Ltd (RGA) including
(Please Print)
it's physicians, nurses, staff and other employees to use and/or disclose my health information per below.

1. The following individual(s) may receive the disclosure of protected health information

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Specific information to be disclosed is: ***(if left blank, complete record to be disclosed)***

Office Notes: ___ Procedure Notes: ___ Lab Results: ___ Pathology Results: ___ Radiology Results: ____

3. I understand that if the person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be disclosed and would no longer be protected.

Consent to Leave Results

Rockford Gastroenterology Associates Ltd. (RGA) may contact you electronically with information that may include, but is not limited to, demographics information (full name, date of birth, etc.), billing information and medical information (diagnosis, medications, test results, etc.)

Home Number: _____ Cell Number: _____

Work Number: _____ Email (via portal) _____

___ Do not leave any information electronically without direct connection

I understand that RGA works to ensure that all data is sent electronically is sent securely but cannot guarantee that the means receiving it is also secure.

I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to RGA. If I revoke this authorization my revocation will not affect any prior actions taken in reliance on my authorization. I understand that I may refuse to sign this authorization and that my refuse to sign in no way affects my ability to receive treatment.

I certify that I have read and understand this authorization and approve of these communication preferences

_____ _____ _____

Signature of Patient or Representative | Patient's Date of Birth | Date

For Patient Representatives:

_____ _____ _____

Printed Name | Relationship to Patient | Authority for Patient Representative Status