AUTHORIZATIO. D USE AND/OR DISCLOSE HEA. I INFORMATION

North Shore Gastroenterology & Endoscopy Center, Inc
850 Columbia Road Suite 200
Westlake, OH 44145
Phone: (440) 808-1212 Fax: (440) 808-0321

Patient Information		Provider Information	
Name		Name	
Address		Address	
Phone		Phone	Fax
Social Security Number	Date of Birth		

I authorize the above referenced provider to use and/or disclose my health information as identified below to: _____ for the purpose(s) of continuity of care and at the request of the individual.
[Provider Name]

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health information and/or records if such information and/or records exist:

____Medical records required for continuity of care
____Laboratory Reports
____Transcribed Hospital Reports
____Other
____Pathology Reports
____Billing Statements
____Radiology Reports

The following items must be initialed to be included in the use or disclosure of other health information:
____HIV/AIDS related health information and/or records
____Mental health information and/or records
____Genetic testing information and/or records
____Drug/alcohol diagnosis, treatment, and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any given time by giving written notice to the Privacy Officer of North Shore. Unless revoked earlier this authorization will expire 180 days from the date of signing or upon [date] _____.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider of health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state and federal regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name of Patient or Legal Representative

☐ Copy of this signed authorization provided to patient or legal guardian