ASHEVILLE GASTROENTEROLOGY ASSOCIATES
(A Division of Digestive Health Partners)
191 Biltmore Avenue, Asheville, NC 28801
Telephone: 828-254-0881 Fax: 828-258-1614

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Patient's Name: _____ Patient's Date of Birth: _____

Patient's Address: _____ Last 4 digits of SSN: _____

City/State/Zip: _____ Day Phone: _____

I do hereby consent and authorize: **ASHEVILLE GASTROENTEROLOGY ASSOCIATES (a Division of Digestive Health Partners)**
191 Biltmore Avenue, Asheville, NC 28801
Phone: (828)-254-0881 (Fax) 828-258-1614

☐ To **release** ☐ To **obtain**

My medical records to/from:

Provider/Organization Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Information to be released (Please provide a specific description of the information to be released):

☐ Lab Results ☐ MD/PA Consults ☐ Procedures ☐ Pathology

☐ Follow-Up ☐ Other: _____

Note: By signing this authorization, you acknowledge that it extends to all or any part of the records designated above, which may include psychiatric information, HIV test results, alcohol/drug abuse, etc., unless specifically excluded by you.

I understand that this authorization will expire on (*please provide date or specify "no expiration"*): _____

_____ _____
Signature of Patient Date

_____ _____
Parent/Legal Guardian/Authorized Person Date

Notice to Patients: The patient or the patient's representative may inspect and/or copy the health information to be used or disclosed in accordance with practice policies. You may refuse to sign this authorization or revoke it in writing at a later date if the information has not already been disclosed. We will not condition treatment or payment on your providing this authorization except in the specific circumstances allowed by the HIPPA Privacy Rule. We cannot protect against the possibility that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by law.