MID-SOUTH
GASTROENTEROLOGY
GROUP

Phillip R. Bowden, M.D., P.A.

Authorization for Release of Information*

- YOU HAVE THE RIGHT TO INSPECT, COPY ANO/OR AMEND INFORMATION TO BE USED OR DISCLOSED.
- YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED
- WE MUST PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.

THIS AUTHORIZATION IS VOLUNTARY

TO BE COMPLETED BY PATIENT OR PATIENT'S REPRESENTATIVE

I, _____Date of Birth_____do hereby authorize the Clinic/Center to obtain, use, disclose or receive my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization to whom I authorize disclosure of my personal data and/or individually identifiable health information is not a health plan, health care provider, or clearinghouse that the released information may no longer be protected by federal privacy regulations.

ATTENTION: PATIENT OR PATIENT'S REPRESENTATIVE PLEASE CHOOSE AND INITIAL A OR B

_____A Complete medical record which may contain treatment notes regarding radiology, pathology (including HIV test results and genetic testing information), immunization, procedure(s), alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2, and other common medical record documentation by the physician, nurse or other ancillary personnel for the entire time I was treated by the practice.

_____B For information collected/services described below and provided during the time period of: _____

_____

Description of records to be released: _____

_____

_____

TO BE COMPLETED BY PATIENT OR PATIENT'S REPRESENTATIVE

Release my records to the following: _____

_____

For the purpose(s) of: _____

_____

I understand that I may withdraw my authorization in writing at any time, except to the extent that action has been taken in reliance on this statement. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

_____ _____

Signature of patient or patient's representative Date

(Form MUST be completed before signing.)

Printed name of patient's representative: _____

Description of the representative's authority to act in behalf of the patient: _____

_____

Relationship to the patient: _____

** For information about how your medical information may be used or disclosed, please see the Patient Privacy Notice.*