PATIENT INFORMATION		
Last Name:	First Name:	DOB:
Address:		
Phone #:		

HIPAA & PHI AUTHORIZATION FORM	
The authorization for release of PERSONAL HEALTH INFORMATION is valid for ***1 year*** from date of signature on this form. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). Gastrointestinal Diseases Inc. may disclose your information (PHI), for treatment, payment, and health care operations purposes with your consent.	
Signature:	Date:
EXLUDE the following information from records released:	

AUTHORIZATION TO DISCLOSE PHI *valid for* ***1 year***
Name of family member or personal representative:

PLEASE MAKE SURE TO FILL OUT BOTH SIDES IN THE ENTIRETY

Signature:	Date: