VERBAL COMMUNICATION RELEASE FORM

Patient Name:_____ Patient ID:_____ D.O.B.:_____

Date:_____ GI Physician:_____

By signing this release, I authorize GI Associates & Endoscopy Center to discuss my health information, in person or by telephone, with the individual(s) and/or organization(s) listed below. I acknowledge that this release is for verbal communication only and does not allow for copies of my medical records to be released.

(PLEASE PRINT NAMES)

Physician: _____ Physician: _____

Spouse: _____ Mother: _____

Father: _____ Guardian: _____

Brother: _____ Sister: _____

Child: _____ Child: _____

Other Relationship: _____ Other Relationship: _____

Other Relationship: _____ Other Relationship: _____

I understand that this authorization authorizes the communication of all medical records including psychiatric, alcohol, drug abuse, and HIV/AIDS records. The use of this information may be protected by Public Law 93-255, Section 408; Public Law 93-282, Section 333; or Federal Regulation 42 CFR, Part 2. The information provided is confidential and any disclosure by the recipients is prohibited.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I acknowledge that I have the right to revoke this release, in writing, prior to its expiration. I further acknowledge that the written revocation will not affect any communication of my medical information to the individual(s) and/or organization(s) listed on this form prior to the time that it is revoked.

_____ _____

Authorized Signature (patient, parent, or legal guardian) Date Signed

VOID 1 YEAR FROM DATE SIGNED

_____ _____

Witness Signature Witness Print Name

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