

SAN FRANCISCO GASTROENTEROLOGY
Authorization for Use or Disclosure of Protected Health Information

The information may be used/disclosed for each of the following purposes:

- At my request (only the patient can check this box)
- For further medical care
- Other: _____
- For payment/insurance
- For employment purposes

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

This authorization is fully understood and is made voluntarily on my part. I release San Francisco Gastroenterology from any legal liability that may arise from the release of information requested.

Signature of patient (or patient's personal representative)

Date

Printed name of patient OR representative

Representative's authority to sign for patient, *(i.e parent, guardian, power of attorney for healthcare, executor)*