SAN FRANCISCO GASTROENTEROLOGY

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Authorization for Use or Disclosure of Protected Health Information

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

- ☑ At my request
- ☑ For payment/insurance
- ☐ For employment purposes
- ☐ Other:_____

I understand that after the custodian of records discloses my protected health information, it may no longer be protected by federal privacy laws.

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)*