SWGA SOUTHWEST GASTROENTEROLOGY ASSOCIATES, P.C.

Patient: DOB:

I authorize _____ to disclose/discuss the following health information to _____

( ) most recent visit
( ) history & physical exam
( ) initial assessment
( ) consultation reports
( ) procedure reports
( ) progress notes
( ) laboratory tests
( ) x-ray reports
( ) pathology reports
( ) entire record
( ) other_____
( ) other_____
( ) other_____

Covering the period(s) of healthcare: From date: _____ to date: _____
From date: _____ to date: _____

Purpose of Disclosure:
I authorize the disclosure of this information for the following purposes(s):
_____
_____
_____

Redisclosure of Health Information:
I understand that the parties disclosing and receiving this information may not redisclose it without obtaining another authorization from me, unless the disclosure is specifically required or permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Patient Rights
I understand that:

The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol and drug abuse. It may also include genetic test results and related patient information.

I can see and copy the health information described above and that I will receive a copy of this authorization form after I sign it.

I can refuse to sign ths authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

I can revoke this authorization by writing to Southwest Gastroenterology Associates at 7788 Jefferson St. NE, Albuquerque NM 87109 at any time, but my revocation will not apply to information that has already been disclosed or used in response to this authorization.

Expiration of Authorization:
Unless revoked earlier, this authorization will expire on_____

I have reviewed and understand this Authorization to disclose/discuss Protected Health Information. I affirm that it accurately reflects my wishes.

Signature_____ Date_____