Southwest Gastroenterology Associates, P.C.
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AUTHORIZATION TO DISCUSS MEDICAL/FINANCIAL INFORMATION

Patient Name	Date of Birth

Southwest Gastroenterology Associates, PC (SWGA) and Southwest Endoscopy LTD (SWE) value the privacy of our patients and are committed to our practice in a manner that promotes patient confidentiality while providing high quality patient care.

I give SWGA/SWE and its departments/employees permission to verbally discuss medical information with the following person(s):

Name	Relationship	Address/Phone number

This is not an authorization to release medical records.

In addition, I give my permission to discuss the following information (**please check all that apply**):

- ☐ Communicable diseases
- ☐ Acquired Immunodeficiency Syndrome (AIDS)/HIV
- ☐ Alcohol and drug abuse
- ☐ Mental health records
- ☐ Genetic information
- ☐ Financial Information

I must notify Southwest Gastroenterology Associates, PC/Southwest Endoscopy LTD in writing if changes are needed. A new form must be filled out. The form with the most current effective date will be active.

This authorization will remain in effect until changed or revoked in writing by me.

Signature	Date