AUTHORIZATION FORM-GENERAL

Use this form for: rent reduction, medication reduction, attorney, interpreter and any specific entity

This authorization form permits: Associates In Gastroenterology, P.A.
1070 Wildewood Centre Drive
Columbia, SC 29229

to use or disclose protected health information listed in the description section below for the following patient:

Name _____ Birth Date _____
Address _____
City/State/ Zip _____

Entity or person to receive the information:
Name _____
Address _____
City/State/ Zip _____

Description of information to be used or disclosed: _____
_____
_____

Purpose of use or disclosure: _____
_____

Expiration date or event: _____
_____

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____Date _____
Signature of Patient or Personal Representative (as defined by HIPAA)

Description of Personal Representative's Authority (attach necessary documentation)
_____
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Office Use Only:

Receiving Employee_____ Date received_____

☐ Copy given to patient