Authorization-Compound

Use form for: All patients to communicate with the following entities: telephone, voice mail, texts, school, employers, parents, spouse and others.

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 to the Entity or Person listed in the Receiving Entity section for you as the patient:

Column A (Receiving Entity)	Column B
Column A: Numbers 1-4 Please complete the appropriate sections below that apply to you disclosing where our office can contact you and leave messages concerning your medical care with our facility.	**Column B: Numbers 1-4** Please check the boxes describing what type of information can be disclosed on the phone numbers given or to the Employer/School listed in Column A.
1. Voice mail: Home #______________________________	**1.** ☐ Appointment time ☐ Results of lab test or x-rays ☐ Other ______________________
2. Voice mail: Business # ______________________________	**2.** ☐ Appointment time ☐ Results of lab test or x-rays ☐ Other ______________________
3. Voice/text mail: Cell phone #______________________________	**3.** ☐ Appointment time ☐ Results of lab test or x-rays ☐ Other _____________________
4. Employer Name ______________________________ School Name ______________________________	**4.** ☐ Appointment or absentee information ☐ Return to work or school information
Column A: Numbers 5-7 List the names and phone numbers of family members and/or friends who you would like to have access to your medical information.	**Column B: Numbers 5-7** Please check the boxes describing what type of information can be disclosed to the people listed in *Column A*.
5. Spouse (Provide name) ______________________________ Telephone Number ___________________	**5.** ☐ Family billing information ☐ Financial information ☐ Medical information- please list ______________________________
6. Parent (Provide name) ______________________________ Telephone Number ___________________	**6.** ☐ Family billing information ☐ Financial information ☐ Medical information- please list ______________________________
7. Other (Provide name) ______________________________ Relationship _______________________ Telephone Number ___________________	**7.** ☐ Family billing information ☐ Financial information ☐ Medical information- please list ______________________________

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Purpose

The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration date or event: This authorization shall be enforce until revoked by the patient or
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Verification method or code: This practice will verify the identity of any entity requesting protected health information. Verification information may include:

THE LAST FOUR OF YOUR SOCIAL SECURITY NUMBER OR THE LAST FOUR OF THE QUARANTOR'S AND YOUR DATE OF BIRTH.

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:

Original is scanned.