GASTROENTEROLOGY CLINIC OF ACADIANA LLC
1211 Coolidge Blvd., Suite 303
LAFAYETTE, LA 70503

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:	DATE OF BIRTH:
SOCIAL SECURITY NUMBER:	
ADDRESS:	
PROVIDER AUTHORIZED TO RELEASE THE HEALTH INFORMATION (THE PROVIDER):	(Name of releasing entity)
ENTITY TO RECEIVE THE HEALTH INFORMATION (THE RECIPIENT):	(Name of receiving entity)
RECIPIENT'S ADDRESS:	
DATES OF SERVICE OF THE HEALTH INFORMATION THAT IS COVERED BY THIS AUTHORIZATION:	
START DATE:	END DATE:

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

	YES		NO	PROGRESS NOTES		YES		NO	DISCHARGE SUMMARY
	YES		NO	LABORATORY TESTS		YES		NO	COMPLETE HEALTH RECORD
	YES		NO	X-RAY REPORT		YES		NO	OTHER(PLEASE SPECIFY):
	YES		NO	CONSULTATION REPORTS					
	YES		NO	HISTORY & PHYSICAL EXAM					

☐ If checked, this is a conditional authorization, and you will not receive the following services unless you sign this authorization (describe any consequences of refusing to sign):

PURPOSE OF USE OR DISCLOSURE:

AUTHORIZATION EXPIRATION DATE OR EVENT:

This authorization to release the health information listed above can be revoked at any time (upon written notification to the Recipient at the above address) except to the extent that (1) Provider has already released the Health Information before being notified of the revocation, or (2) Provider has taken action in reliance on this authorization. Provider's Notice of Privacy Protections contains more information on how to revoke this authorization. This authorization will expire on the expiration date or event listed above.

When the Patient's health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the Recipient or any of its agents and/or employees and may no longer be protected by 45 CFR Parts 160 and 164.

The undersigned patient (or personal representative on behalf of the patient) hereby authorizes the Provider named above to release the Health Information described above to the Recipient named above. The patient has the right to refuse to sign this authorization.

The provider can condition treatment, payment, enrollment, or eligibility for benefits on the patient providing this signed authorization,except in very limited circumstances. If this is one of those circumstances, the consequences of refusing to sign are described above.

The Patient has the right to inspect and copy his health information that is included in a designated record set, subject to the exceptions found in 45 CFR 164.524.

SIGNATURE:	DATE:
AUTHORITY TO SIGN IF NOT PATIENT:	