GI Associates of Maryland
HIPAA Authorization Form

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize GI Associates of Maryland to use and/or disclose certain protected health information (PHI) about me to (list persons you give us authorization to communicate with via phone and/or email:

- _____
- _____
- _____

This authorization permits GI Associates of Maryland to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

_____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____

The Practice will ___ will not _X__ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from GI Associates of Maryland. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclose by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

GI Associates of Maryland, 3510 Old Washington Road, Suite 201, Waldorf, Maryland 20602
Office (301) 645-8035
Fax (301) 645-5229

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date