145 Wyckoff Rd Eatontown NJ 07724 Suite 201 732-597-7333
GorceyMD@MonmouthDigestiveHealth.com

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: ____

Date of Birth: ____________________ SSN: ____________________

I. My Authorization

I authorize the following using or disclosing party:

____

to use or disclose the following health information.

☐ - All of my health information

☐ - My health information relating to the following treatment or condition: Gastrointestinal related history including office notes, endoscopy and pathology reports, bloodwork, radiological exams and any other information pertinent to my gastrointestinal related treatment.

☐ - My health information covering the period from ___________ (date) to __________ (date)

☐ - Other: ____

The above party may disclose this health information to the following recipient: BY FAX OR EMAIL TO:

Monmouth Digestive Health / Dr Steven A Gorcey

145 Wyckoff Road suite 201, Eatontown, New Jersey 07755

Phone **732 – 597 – 7333** Fax **732 – 597 - 7484**

Secure Email GorceyMD@monmouthdigestivehealth.com

The information may also be sent directly from your electronic health system to That of Monmouth Digestive Health if there is compatibility (i.e.: GMED to GMED)

The purpose of this authorization is (check all that apply):

☐ - At my request

☐ - Other: ____

This authorization ends:

☐ - On (date)__________________

☐ - When the following event occurs: ____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: ________________________________

Date: __________________

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: _____________ years of age

☐ - Patient is unable to sign because: ____

Signature of Authorized Representative: ______________________________________

Date: _________________

Print Name of Authorized Representative: ____

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: ______________________

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _______________________________

Date: ___________________ Time: ______________________

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _______________________________

Date: ___________________ Time: ______________________