GASTROENTEROLOGY CLINIC OF SAN ANTONIO, P.A.

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AUTHORIZATION TO RELEASE
PHI (Personal Health Information)

I, _____, DOB: _____,
(Patient name-Please PRINT)
Authorize Gastroenterology Clinic of San Antonio to release any Personal Health Information (PHI) as stated below and in accordance to current HIPPA regulations.
(A copy of this form must be presented to Patient before leaving facility)

Re: Authorization is given to release my PHI and/or Insurance Information either **verbally over telephone** or **in person** to: (Specify with complete name & DOB)

Parent: _____

Spouse: _____

Legal Guardian: _____

Child / Children: _____

Other: _____

Re: Authorization is given to release my PHI and / or Insurance information by **Mail or Fax** to: (Specify with complete name & DOB)

Parent-Address / Fax: _____

Spouse-Address / Fax: _____

Legal Guardian-Address / Fax: _____

Child / Children-Address / Fax: _____

Other: _____

X_____ Date: _____
(Patient Signature)

FOR OFFICE USE ONLY
( ) Authorization received by _____on_____.