GastroArkansas Powered by The GI Alliance
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Authorization to Release Protected Health Information

Patient Name: _____ Birth Date: _____/_____/_____

I authorize Gastro Arkansas d/b/a GI Alliance on behalf of itself and all other practices that are operating as a single HIPAA Affiliated Covered Entity (collectively "Provider") to use and disclose the information described below to the following recipient(s):

Recipient: _____
Address: _____
Phone: _____ Fax:_____

This authorization applies to the following types of information (check one):

[ ] all information about Patient held by Provider including full copies of medical records, which will include but not be limited to, diagnosis information, records of treatment received, laboratory test results, and appointment records.

[ ] only the following information (check applicable boxes/ fill out description):
[ ] medical records for Patient from _____ date through _____ date.
[ ] other: _____.

If initialed below, Provider is authorized to include the following types of information if they are included in the records I have authorized to be disclosed:

____ HIV/AIDS-related information (including test results)
____ Mental health information (except psychotherapy notes)
____ Drug, alcohol or substance use disorder information
____ Genetic information (including genetic test results)

The purpose of this authorization is (check one)
[ ] at Patient's request [ ] Other (please specify) _____.

This authorization will be effective for one (1) year from the date signed below or the date on which Patient no longer receives services from Provider, whichever is later. I have the right to revoke this authorization at any time by notifying Provider at Gastro Arkansas, 11700 Cantrell Rd., Little Rock, AR 72223; Attn: Privacy Officer. My revocation must be in writing. My revocation will not be effective to the extent Provider has already relied upon this authorization (by using or disclosing information).

Signing this form is optional. Provider will not condition Patient's treatment or payment for care on whether I sign this form. Once information is disclosed as a result of this form, it may no longer be protected by the federal HIPAA privacy rules. I may obtain a copy of this form by contacting the Privacy Officer at the address listed above.

_____ _____/_____/_____
Signature of Patient or Patient's Representative Date

If signed by the Patient's representative, description of authority (such as parent/ guardian):

_____