

AUTHORIZATION TO INDIVIDUALS

For release of Medical Information

I, _____, give all physicians and professional staff

employed by Northwest Arkansas Gastroenterology Clinic, P .A. permission to disclose the private health information set forth below to the following people at the request of one or more of these individuals.

The specific information these persons may receive is as follows:

Please Print:	Name	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I also give Northwest Arkansas Gastroenterology Clinic, P.A. permission to leave a message(s) on my answering machine if they should need to remind me of an appointment, change an appointment, etc, and if they are unable to reach me in any other way.

_____ **YES** or _____ **NO**

I understand that Northwest Arkansas Gastroenterology Clinic, P.A. will not release any information to any person(s) not listed above.

In addition, I understand or acknowledge the following:

1. I have the right to revoke this Authorization at any time by giving Northwest Arkansas Gastroenterology Clinic, P.A. a written notice at the address set forth above.
2. I have received from Northwest Arkansas Gastroenterology Clinic, P .A. a Notice of Privacy Practices.
3. My private health care information may be subject to re-disclosure by one or more of the persons named above and as such will no longer be protected.

This Authorization shall expire on the _____ day of _____, 20_____.

Please Print

Patient Name _____	Date of Birth _____
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In the event the Authorization is being executed by a personal representative, guardian, or parent, please print your name and relationship to the patient.
