



AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

(used for disclosure/use of information that is not contemplated or covered by the Notice of Privacy Practices or by a Consent; mainly used for non-routine disclosures/uses)

I, _____, (name of Patient) hereby authorize GI CARE CENTER, A DIVISION OF GASTRO HEALTH ("the Provider") to use or disclose the following protected health information: *(Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc. wherever available)*

The protected health information may be disclosed to: *(Insert name of person or entity who may have or may receive the information)*

This protected health information is being used or disclosed for the following purposes: *(List specific purposes here, the patient may indicate that the information to be disclosed is "at the patient's request" if the patient does not choose to provide an explanation of the purpose of the request)*

This authorization shall be in force and effect until: (check one of the following)

- Date _____
- The happening of the following expiration event: _____
- End of research study
- No expiration date (can only be used if authorization is for creation of research database or research repository) at which time this authorization to use or disclose this protected health information expires.

I understand that, as set forth in the Provider's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to: **GI CARE CENTER, A DIVISION OF GASTRO HEALTH, 7500 SW 87 Avenue, Suite 200, Miami, FL 33173, ATTN: Privacy Officer**

I understand that a revocation will not be effective to the extent that the Provider has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Check One of the Following:

- I understand that the Provider will not condition my treatment on whether I provide authorization for the requested use or disclosure.
- I understand that the health care provided by the Provider is solely for the purposes of creating protected health information for (INSERT THIRD PARTY) _____ and that my authorization is a condition of this treatment. I understand that if I do not sign this authorization, then the Provider will not provide health care services to me.
- I understand that the treatment being provided for the Provider is related to research and that my authorization of disclosures for research related purposes is a condition of this treatment. I understand that if I do not sign this authorization, then the Provider will not provide research-related treatment to me.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent that it provides greater access rights.)
- Refuse to sign this authorization.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

A copy of the signed authorization should be provided to the patient. If the Provider is requesting this authorization for its own purposes, the Provider must provide the patient with a copy of the signed Authorization.