NEW YORK GASTROENTEROLOGY ASSOCIATES

AUTHORIZATION TO RELEASE MEDICAL

INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your healthcare provider or staff of New York Gastroenterology Associates to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I do not authorize **New York Gastroenterology Associates** to release any or all information concerning my medical care to any individual except as set for above.

_____ I do authorize **New York Gastroenterology Associates** to verbally release any or all information concerning my medical care to the following individuals:

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Patient Signature	Date
_____	_____
Print Patient Name	Date of Birth
_____	_____
Witness Signature	Date