The Goldenberg GI Center, LLC
2920 N Cascade Ave 2nd Floor
Colorado Springs, CO 80907
Tel (719)377-6609
Fax (888)972-4399
info@goldenberggicenter.com
www.GoldenbergGIcenter.com

HIPAA Privacy Authorization Form

***Authorization for Use and Disclosure of Protected Health Information*
*(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)***

1. Authorization

I _____ (your name), authorize _____ (healthcare provider that has needed records) to use and disclose the protected health information described below to The Goldenberg GI Center and Dr. Goldenberg.

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ All past, present, and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

B. ☐ I authorize the release of my complete health record with the exception of the following information:

⬚ Mental health records

⬚ Communicable diseases (including HIV and AIDS)

⬚ Alcohol/drug abuse treatment

⬚ Other (please specify):_____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until_____(date you'd like access to end), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

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

_____/_____

(Signature of patient or personal representative) Date

_____

(Printed name of patient or personal representative and his or her relationship to patient)