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Atlanta Gastroenterology Specialists PC

www.atlgastrospec.com

Release of Information

Section I

- I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities or any healthcare professional requiring this information.
- I hereby assign and authorize payment to Atlanta Gastroenterology Specialists PC of all medical and/or surgical benefits, including major medical policies, to which I am entitled to under any insurance policy or policies, under any self-insurance program, or under any benefit plan.
- I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to Atlanta Gastroenterology Specialists PC by any insurance policy, self-insurance program or other benefit plan.
- This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Section II

Check one: *I [☐ **DO]** or [☐**DO NOT]** authorize you to contact or leave messages at my place of work.*

Check one: *I [☐ **DO]** or [☐**DO NOT]** authorize you to contact me at my e-mail address.*

E-mail address if authorized _____

*I **DO** authorize you to share information with:*

Name & Relationship: _____

I hereby authorize you to leave messages on my home answering machine regarding appointments and to inform me that laboratory results are available. [The laboratory results are NEVER left on the answering machine. You have to call the office to get them.]

Patient Name: _____

Patient Signature (Parent if patient is a minor): _____

Relationship to patient if not patient: _____

Date: _____