STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Patient Label

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow Norman Endoscopy Center, LLC to share my protected health information.

III. AUTHORIZATION & INFORMATION TO BE SHARED

I authorize Norman Endoscopy Center, LLC as set forth below, to share my protected health information for reasons in addition to those already permitted by law.

A. Persons/Organizations (other than medical providers or facilities) Authorized to Receive My Information:

Name Relationship

_____

_____

_____

B. Information to be shared:

1. Check one or more boxes below.

_____ Entire Medical Record _____ Procedure Report _____ Pathology Report

_____ Other: _____

IV. EXPIRATION & REVOCATION

A. This Authorization Will Expire (**must choose one**):

_____ 3 years after last procedure encounter. ____ Other _____
(Insert Date of Event)

B. Right to Revoke

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
2. I understand if the person/organization authorized to receive my protected health information is not a health plan or healthcare provider, privacy regulations may no longer protect the information.
3. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.
4. I understand Norman Endoscopy Center, LLC may utilize an electronic network to exchange my protected health information with other providers unless I choose not to participate.
5. I acknowledge information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

B. Signature (This document must be signed by the individual or the individual's legal representative).

_____ _____ _____

Signature (Patient or Legal Representative) Relation to Patient Date