sonoran
gastroenterology | endoscopy

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HIPAA PROTECTED HEALTH INFORMATION FORM

Name: _____ DOB: _____/_____/_____

I authorize Sonoran Gastroenterology to release and/or discuss protected health information pertaining to my care to the below listed individuals. I realize that if I've listed an emergency contact on my registration paperwork, and I want them to have access to my protected health information, that I must list them below. I also understand that I may revoke access to the listed individuals at any time. I also understand the withdrawal must be in writing.

Name | Relationship | Telephone Number

1. _____

2. _____

3. _____

4. _____

_____ I do not authorize my medical records to be released or discussed with anyone.

_____
Signature of Patient or Legal Representative

_____
Printed Name

_____
Date