Mid-Valley Gastroenterology Associates, Inc
Authorization for Use or Disclosure of Protected Health Information

I, ____, hereby authorize Mid-Valley Gastroenterology Associates, Inc to (check the following that apply):

☐ use the following protected health information, and/or

☐ disclose the following health information to: ________________________________
____
____

(Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors, such as date of service, type of service provided, level of detail to be released, origin of information, ect.)

This protected health information is being used or disclosed for the following purposes:
____
____
(List specific purposes above.)

This authorization shall be in force and effect until ______________________________
(SPECIFY DATE OR EVENT THAT RELATES TO THE PATIENT OR THE PURPOSE OF THE USE OR DISCLOSURE) at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Ms. Bonnie Smith at Mid-Valley Gastroenterology Associates, Inc. I understand that a revocation is not effective to the extent that Mid-Valley Gastroenterology Associates, Inc has relied on the use or disclosure of the protected health information.

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

Mid-Valley Gastroenterology Associates, Inc will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

____ ____________________
Signature of Patient or Personal Representative Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority