GI Gastrointestinal Institute, LLC
Premier Medical Group, LLC

ENDOSCOPY IMAGING LABORATORY

STEPHEN S. MATTER, M.D.

Patient Name ______________________________
Last First Middle Initial

Medical Record # ______________

Former Name (if any) ______________________________
Last First Middle Initial

Date of Birth ____/____/____

Daytime Telephone (____) ______________________

Social Security # ____-____-____

I authorize the following organization to release information as stated below from the patient health information record.

This authorization covers the time period beginning: ____/____/____ (date) and ending: ____/____/____ (date).

INFORMATION TO BE RELEASED *FROM:*	INFORMATION TO BE RELEASED *TO:*
❑ Premier Medical Group, LLC dba Illinois Gastroenterology, Ltd. ❑ Gastrointestestinal Institute, LLC ❑ ______________________ Organization/Person Name ______________________ Street Address ______________________ City, State, Zip ______________________ Telephone Number	❑ Premier Medical Group, LLC dba Illinois Gastroenterology, Ltd. ❑ ______________________ Organization/Person Name ______________________ Street Address ______________________ City, State, Zip ______________________ Telephone Number

TYPE OF RECORDS REQUESTED (Charges for copies of records may be associated with your request)	
❑ Health care information related to the following treatment or condition: ______________________ ______________________ ❑ Laboratory/Diagnostic Tests: ______________ ❑ Other: ______________________	Sensitive Records require specific patient authorization. **Please initial the appropriate records requested:** ____ Drug and/or Alcohol Abuse ____ Mental Health (may include Pain Management or Psychiatry records) ____ Sexually Transmitted Diseases (includes AIDS/HIV)

Purpose or Need for this information: ❑ Continuing Care ❑ Copies for own use ❑ Other ______________

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when Mid-Central Illinois Gastroenterology has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. To revoke an authorization, (1) Complete a Revocation of Authorization form, which is available from Mid-Central Illinois Gastroenterology; or (2) Write a letter to Mid-Central Illinois Gastroenterology.

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.

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) except when (1) my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party, or (3) an authorization is required for health plan eligibility or enrollment or a risk rating determination. Failure to sign an authorization may result in inability to obtain certain benefits in these cases.

I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize the release of patient information to the above named person or organization.

____/____/____ ______________________ ______________________
Date **Signature of Patient or Legally Responsible Party** **Authority to sign, if not Patient**

This authorization is not valid to release future health care more than 90 days from the date signed (except to a payer or as otherwise permitted under law). It will expire in 90 days unless otherwise specified ______________________ (date/event).

07/01/2013