CINCINNATI GI

CGI HIPAA Policy upon request

PART 1: CONSENT FOR RELEASE OF INFORMATION

I_____, hereby authorize Cincinnati GI physicians and/or staff to disclose my health information to the following people who are involved in my care.

If **no** then please skip to Part 2 at bottom of this page.

_____ (*check only if yes*) Authorization to release information to person(s) mentioned below:

Person's Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____

PART 2: MESSAGE AUTHORIZATION

_____(*check only if yes*) Authorization to leave messages on an answering machine/voice mail if there is no answer at the number provided with a detailed test or procedure results.

I understand that I may revoke this consent at any time by notifying Cincinnati GI in writing.

X_____ _____

(Signature of patient or POA) (Date)