

# AUTHORIZATION TO RELEASE HEALTH INFORMATION

Fayetteville Gastroenterology Associates, P.A.  
2041 Valleygate Dr • PO Box 87229  
Fayetteville, NC 28304

*Expires upon one time release.*

PATIENT INFORMATION	
Name of Patient: <i>(Last, First, M.I.):</i>	Date of Birth:
Address:	
City:	State: Zip:
<b>I authorize the practice below to release my health information:</b>  Fayetteville Gastroenterology 2041 Valleygate Drive FAYETTEVILLE, NC 28304	
<b>Please forward/release my health information to:</b>	
<b>The information below is provided at the request of the patient. (Describe PHI to be released):</b>	
<b>This authorization shall be in effect until the information has been forwarded as requested.</b>	
<b>Patient Information:</b> I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. <i>I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.</i>  I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.  I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to: _____	
<b>Signature</b>	
<i>Signature of Patient or Personal Representative</i>	<i>Date</i>