AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

ACADIANA GASTROENTEROLOGY ASSOCIATES, LLC
439 Heymann Blvd
Lafayette, LA 70503
(337) 269-0963

and

ACADIANA ENDOSCOPY CENTER, INC.
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(337) 269-1126

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As required by the Health Insurance Portability and Accountability Act of 1996, Acadiana Gastroenterology Associates, LLC and Acadiana Endoscopy Center, Inc., may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time in writing by contacting our office at the address above, attention Privacy Official.

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed:

_____

_____

_____

Person or entity requesting the information to be used or disclosed (Company or Entity name):

_____

Recipient of the information (Name of individual receiving the information):_____

This information is being requested for the following purpose(s):

_____

_____

This Authorization shall remain in effect from the date signed below until: _____
Expiration Date or Event

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Official
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and therefore will no longer be protected by HIPAA
- My health care and the payment for my health care will not be affected if I do not sign this form

_____ If an "X" is indicated in the space on the left, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name: _____ Patient Signature: _____

Date: _____ Relationship if signed by Personal Representative: _____

Patient Account Number: _____ Patient Date of Birth: _____