MONTEREY BAY GI CONSULTANTS MEDICAL GROUP Inc.
MONTEREY BAY ENDOSCOPY CENTER LLC

23 Upper Ragsdale Drive, Monterey, CA 93940
601 E. Romie Lane, Suite #1, Salinas, CA 93901
P 831.375.3577 F 831.375.1478

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individual identifiable health information except as provided in our Notice of Privacy Practices without your authorization.

Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. To be valid, this form must be filled out COMPLETELY.

Patient's Name: _____ **DOB:** _____ **Telephone:** _____

Patient ID (*For office use only*): _____

I authorize Monterey Bay Gastroenterology Medical Group Inc. and Monterey Bay Endoscopy Center LLC to discuss/grant access to my

___ Medical Appointments
___ Medical Questions
___ Medical/Mental Health Records excluding HIV and AIDS
___ Tests Results
___ Billing Information

with/to the following individual(s) over the phone, in writing and face-to-face

Name (First and Last)	Relationship to Patient	Phone

This authorization form does not apply to the dispensing of prescriptions, medications, and samples.

I understand that Monterey Bay GI Consultants Medical Group Inc. and Monterey Bay Endoscopy Center LLC may not disclose the medical information unless authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand this authorization may be revoked in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

I understand that I have a right to receive a copy of this authorization. **Unless otherwise revoked, this authorization will not expire.**

I understand that I do not have to sign this form, and that I should only sign if I want my medical provider or my clinic to share my information with the individual(s) listed above.

_____ _____

Signature of Patient or Legal Healthcare Representative **Date**