Etowah Gastroenterology Associates

HIPAA FORM

Request for Restrictions on Uses/Disclosures of Health Information

DATE: ______________________

BY LAW, All medical information is confidential unless written authorization is given. Therefore, by signing this form, I _______________________________________ am authorizing ETOWAH GASTROENTEROLOGY ASSOCIATES to give medical information to:

_______DO NOT DISCLOSE ANY MEDICAL INFORMATION TO ANYONE OTHER THAN MYSELF

Signature of Patient

THIS REMAINS IN EFFECT UNTIL I GIVE WRITTEN NOTIFICATION TO DISCONTINUE

Signature of Patient DATE