GASTROENTEROLOGY ASSOCIATES OF CENTRAL VIRGINIA, INC.

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

I give permission for Gastroenterology Associates of Central Virginia, Inc. to discuss my Protected Health Information with the person(s) listed below. Protected Health Information includes but is not limited to diagnosis, current treatment, future treatment, appointments, medications, billing and insurance issues.

NAME	RELATIONSHIP & PHONE NUMBER	

______________________________ Signature of Patient or Legal Guardian

______________ Date

______________________________ **Patient's Date of Birth**

*Anyone calling to discuss your Protected Health Information must be on this list and must be able to give us the "**Patient's Date of Birth**" as indicated on this form.