



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
_____	_____
_____	_____
_____	_____
_____	_____

**Patient Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**\*\*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.\*\***

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