HIPAA PRIVACY AUTHORIZATION FORM

I,_____, hereby authorize Gastroenterology of West Central Ohio, Inc. to release information to the following friends and family members regarding my health care.

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

☐ Do not discuss/release any of my health care information to anyone but myself.

_____ _____

Signature of patient or patient's representative Date

You have the right to receive a copy of our HIPAA privacy statement