John G. Stagias, M.D. 428 Hamilton Street Southbridge, MA 01550 Tel. (508) 765-1600 Fax (508) 765-0253

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for ALL authorizations.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider the

ate of Birth:		ID Number:	
organization providing th		Organization receiving the informat	ior
			•
lisclosed:		n (including date(s) of health care) t	
		if a health plan or health care provide	
equested the authorizat	ion.		
a. What is the pu	pose of the use CONTINUITY	OF CARE	
b. Will the health	r in-kind compet	n care provider requesting the authorizensation in exchange for using or disclosing YES NO	zati

Gastroenterology

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Section C: Must be completed for ALL authorizations:

The p	patient or the patient's representative must read and initial	the following statements:
1.	I understand that this authorization will expire on/_	/ Initials
2.	I understand that I may revoke this authorization at a providing organization in writing. Should I do so, this affect on any actions taken by the providing organization revocation.	action will not have any
X _s	ignature of patient or patient's representative	Date
	, , , , , , , , , , , , , , , , , , ,	
Print	ed name of patient's representative:	
Rela	tionship to the patient:	

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

This form may not be use to release information for treatment or payment except when the information released is psychotherapy notes or certain research information.