From the office of DAVID E. WEXLER, M.D., F.A.C.G., A.G.A.F.
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Authorization for Release of Information to Drs. Wexler, Lesser & Shrensel

SECTION A: ***Must be completed for ALL authorizations***

I hereby authorize the use or disclosure of my individually identifiable health information (which specifically identifies me or which can reasonably be used to identify me to carry out treatment, payment and health care operations) 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 released information may no longer be protected by federal privacy regulations.

Patient Name: **Date of Birth:**

In the event that you want any of your Protected Health Information sent to another organization (i.e. insurance company for application of health or life benefits, lawyers' offices, etc.), you must complete the following:

Organization providing the information	**Organization receiving the information**

Clearly specify which information (including date(s) of healthcare) to be disclosed:

SECTION B: ***Must be completed ONLY if a health plan or health care provider has requested the authorization.***

1. The health plan or health care provider must complete the following:
   a) What is the purpose of the use or disclosure?
   GI EVALUATION

   b) Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?
   ☐ YES ☒ NO
2. The patient or the patient's representative must read and initial the following statements:
   a) I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
   Initials: _____

   b) I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it.
   Initials: _____

SECTION C: ***Must be completed for ALL authorizations:***

The 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 any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation.
   Initials: _____

Signature of patient or patient's representative **Date**
(This form MUST be completed before signing)

Printed name of patient or representative: **Relationship to patient**