AGIS Alexandria GastroIntestinal Specialists

3311 Prescott Road, Suite 411
Alexandria, LA 71301
(318)448-5310

HIPAA Release of Medical Information

Patients Name: _____

Please Print Clearly

I authorize AGIS to release my medical, including Prescriptions, X-rays, orders, doctor excuse, etc. and billing information to: (This is not a records release, only information requested) **If you circle YES (Y), please list a name:**

Spouse: _____ YES or NO

Parents: _____ YES or NO

Children: _____ YES or NO
Children: _____ YES or NO
Children: _____ YES or NO

Siblings: _____ YES or NO

Others: _____ YES or NO
Others: _____ YES or NO
Others: _____ YES or NO

Authorization to leave appointment information with:

Home: _____**Y or N** Work: _____ **Y or N**

Relative: _____**Y or N** Text: _____ **Y or N**

Email: _____@_____ **Y or N**

OR

- DO NOT LEAVE MESSAGES

Signature of Patient or Legal Guardian:

_____***Date***_____

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MEDICAL BENEFITS/PRIVACY PRACTICE

Patient: _____ Date: _____

- I request that payment of authorized **Medical Benefits** be made either to me or on my behalf to Alexandria GastroIntestinal Specialists for any services furnished to me by that provider.
- I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits payable for related services.
- I acknowledge that I have received the **Notice of Privacy Practice** from Alexandria GastroIntestinal Specialists and it is my responsibility to read its contents.
- I understand that my doctor at AGIS may require in the course of my treatment that I have Lab work, Radiology, procedures and etc that will be performed by offices other than AGIS and that they will send me statements from their offices and that AGIS is in no way responsible for their billing practices.
- I acknowledge that the office of AGIS has notified me of the option to access my medical records through the Patient Portal and HIE (Health Information Exchange). I have chosen to:
    - Accept and provide my email address for the Patient Portal

      EMAIL ADDRESS: _____
    - Decline the use of the Patient Portal

Signature of **PATIENT** (or Guardian) that you have reviewed/understood the above statements.

_____