SIBO
CENTER FOR DIGESTIVE HEALTH

Authorization to Disclose Protected Health Information

From The NUNM SIBO Lab

NUNM SIBO LAB
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Patient Information

Patient Name: _____ **Date of Birth:** __/__/___ **Phone:** _____

Address: _____
Mailing Address *City* *State* *Zip*

I hereby authorize NUNM to disclose my healthcare information to:

Name: _____ **Phone:** _____

Address: _____
Mailing Address *City* *State* *Zip*

Please send information by (select 1 option): ☐ **Postal Service, using address above**

☐ **Email:** _____ ☐ **Fax (number):** _____

About your authorization:

This authorization is only for the NUNM SIBO Lab to release SIBO results.
This authorization will expire 180 days from the date of signing.
As required by the Privacy Regulations, NUNM Clinics may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.
Understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.
The lab is required to wait 7 days to release results directly to patients after sending results to the ordering physician/provider, unless otherwise authorized by the ordering physician/provider.
Results sent by email will be sent via an encrypted program. If no option is chosen, results will be sent by postal mail service.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.
7. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits, whether or not I provide authorization to use or disclose Protected Patient Health Information.

_____ ____/____/_____
Signature of Patient / Parent / Guardian *(relationship)* *Date*