AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of North Texas Gastrointestinal Associates, Shawn W. Panzer, M.D. PA to discuss your condition with members of your family or other individuals that you designate, we must obtain your written authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to severity of your medical condition, the law stipulates that these rules may be waived.

___ I **do not** authorize North Texas Gastrointestinal Associates, Shawn W. Panzer, M.D. PA to release any or all information concerning my medical care to any individual except as set forth above.

___ I **authorize** North Texas Gastrointestinal Associates, Shawn W. Panzer, M.D. PA to verbally release any or all information concerning my medical care to the following individuals.

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Patient Name	Date of Authorization

Print Patient Name	Date of Birth	Social Security Number

Witness Signature	Date