HALIFAX GASTROENTEROLOGY, PC
1007 GREGORY DRIVE
ROANOKE RAPIDS, NC 27870
(252) 535-6478

INDIVIDUAL PATIENT'S HIPAA AUTHORIZATION

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of organizations named in this form.

PRINT NAME:_____ SIGNATURE:_____

DATE OF BIRTH:_____ DATE SIGNED:_____

If this authorization is signed by a personal representative for the individual patient:

Personal Representative's Name: PRINT:_____

SIGNATURE:_____

Relationship to Individual Patient:_____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.