Jeffrey P. Fenyves, M.D. | Stephen W. Fry, M.D.

The state-of-the-art procedure center supporting several regional clinics.

The Center for Digestive Wellness | 10461 Wallace Alley Dr. | Kingsport TN 37663 | ph 423.279.1400 | fx 423.279.1410

I hereby authorize *The Center for Digestive Wellness/Tri-Cities Gastroenterology* to release/obtain my individually identifiable health information as described below to the following individual(s) or entity (ies). I understand that once this information is disclosed, it may no longer be protected by federal privacy regulations.

Person/entity authorized to receive the information ______________________________

Address ______________________________

Phone______________________________ Fax ______________________________

Information to be disclosed______________________________

The information will be used or disclosed for the following purpose(s) ______________________________

____

❏ To assist in the provision of services, care, and treatment of the individual. ______________________________

____

❏ At the request of the individual. ______________________________

____

❏ Other: ______________________________

I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that my refusal will not affect my eligibility for benefits, payment for coverage of services, or ability to obtain treatment except as provided under number five below.

1. I understand that I may revoke this authorization at any time by notifying *The Center for Digestive Wellness/ Tri-Cities Gastroenterology* in writing, except to the extent that (a) action has been taken in reliance on this authorization, or (b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
2. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, *The Center for Digestive Wellness/Tri-Cities Gastroenterology* reserves the right to deny that health care.
3. I understand that I may inspect and/or copy the information used or disclosed.
4. This authorization expires one (1) year from the date executed unless otherwise specified below.

____
Printed name of Patient   Date of Birth   Social Security Number

____
Signature of Patient or Patient's Representative   Date

____
Printed name of Patient's representative   Relationship to Patient or Authority to act for this Patient

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

(Patient will receive a copy of this authorization)

Providing you with the quality care we expect for our own family.

01/01/08