SAGA San Antonio Gastroenterology Associates & Endoscopy Centers

# HIPPA AUTHORIZATION FOR FAMILY AND FRIENDS

I hereby authorize San Antonio Gastroenterology Associates, P.A. to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and other health care operations. My protected health information may be released to the follow individual(s).

| Name | DOB | Relationship |
|---|---|---|
| Name | DOB | Relationship |

I acknowledge that I have been provided the "Notice of Privacy Practices" for San Antonio Gastroenterology Associates, P.A.
I acknowledge that I have completed this from and certify that I am the patient or duly authorized to finish the information requested.

| Patients Signature | Date |
|---|---|

Expires 1 year after signing.
**You may revoke this authorization in writing at any time by notifying your

Healthcare provider in writing or in person only.