ADVANCED DIGESTIVE CARE
GASTROENTEROLOGY ASSOCIATES

Edward C. Kim, M.D., Jin H. Park, M.D., Myung Choi, M.D.
Darren S. Baroni, M.D., Nina Phatak, M.D., Paul O. Arnold, M.D.
Tinatin O'Connell, M.D., Rizwan Ahmed, M.D., Mylan Satchi, M.D.

Christa M. Purdum, PA-C, Michelle D. Bachtold, PA-C
Audra Ballash, PA-C, Jackie Ramirez, PA-C., Kibbum Kang, NP-C
Crystal McGovern, NP-C, Melissa Nemeth, NP-C

Manassas Office
8640 Sudley Rd, Ste 201
Manassas, VA 20110
Phone: (703) 368-6819
Fax: (70) 330-2923

Administrative / Billing Office
8640 Sudley Rd, Ste 207
Manassas, VA 20110
Phone: (571) 428-2969
Fax: (571) 428-2973

Warrenton Office / Endoscopy Suite
170 W Shirley Ave, Ste 205
Warrenton, VA 20186
Phone: (540) 347-2470
Fax: (540) 349-4683

Gainesville Office / Endoscopy Suite
7915 Lake Manassas Dr, Ste 302
Gainesville, VA 20155
Phone: (571) 248-0653
Fax: (571) 248-0658

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

ADC - Gastroenterology Associates is authorized by me to use or disclose my Protected Health Information (PHI) for a purpose of treatment, payment, or healthcare operations. I have read this authorization and understand the designated information will be disclosed only to the recipient(s) outlined below. I specifically authorize any current employee or owner of ADC - Gastroenterology Associates to disclose the information as outlined. I further understand that I retain the right to revoke this authorization in writing at a later date.

You may disclose the following health information (check all that applies):

_____ Entire Medical Record

_____ Certain Medical Data / Information as related to:
( ) Date of service(s): _____
( ) Specific service(s) or procedure(s): _____
( ) Specific condition(s): _____
( ) Specific medication(s): _____
( ) Other: _____

This authorization permits ADC - Gastroenterology Associates to send the protected health information to:

_____

_____

_____

The patient has the right to revoke this authorization in writing. In order for the revocation of this authorization to be effective, ADC - Gastroenterology Associates. must receive the revocation in writing by Certified U.S. mail or FAX at this number (571) 428-2973.

This authorization shall expire on _____ or NEVER. After this date, ADC - Gastroenterology Associates can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____

Patient or Legal Guardian Signature **Date**