

Digestive Specialists, P.A.

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AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name: _____

Address: _____
Mailing Address
City
State
Zip Code

Date of Birth: _____ Social Security: _____

AUTHORIZES: DIGESTIVE SPECIALISTS, P.A.

To release the following information to:

Name of person/facility: _____

Address: _____
Mailing Address
City
State
Zip Code

- Progress Notes Operative Reports Lab Reports X-Ray Reports
 Pathology Reports HIV Test Results Other (please specify) _____

Records of care from the following dates: _____ to _____
___ Mail Records
___ Fax Records # _____

Purpose of Disclosure: Medical Care Insurance
 Attorney Other (please specify) _____

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall **not expire**; or shall expire in **180 days** from the date of my signature, unless specified in writing here. (Please choose one of the above.)

Patient's Signature

To The Party Receiving This Information:

I, the undersigned, have read the above and authorize the person or facility noted above to disclose such information as herein contained. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility or Physician from all liability and damages resulting from the lawless release of my Protected Health Information.

Patient's Signature

Witness

Date

Date

___ Patient notified by ___ fax, ___ mail, or in ___ Office of Record Charge Policy. ___ Staff Initials