

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 Number: _____

Authorizes: Name of Facility/Physician: _____

Address: _____

City, State, Zip Code: _____

Please release the following medical information to:

Digestive Specialists, P.A.

- Progress Notes Operative Reports Lab Reports X-Ray Report
- Pathology Reports HIV Test Results Other (please specify) _____
- ___ Mail Records ___ Fax Records

Purpose of Disclosure: Medical Care

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 Releasing 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 any 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 lawful release of my Protected Health Information.

Patient's Signature

Witness

Date

Date