

Digestive Health Specialists, P.C.

Authorization for Release of Protected or Privileged Health Information

- Used to release copies of health or medical record to patient or to another facility on behalf of the patient, for the patient to request a review of their health medical record and/or to obtain copies of health or medical record from another facility

Patient Name _____ Date of Birth ____/____/____

Telephone Contact (_____) _____ - _____

I _____ do hereby authorize _____
(Patient Name) (Facility)

to release my protected health information including copies of my medical record of care received at the above named facility to the persons or facilities listed below and for the purpose cited below:

Release requested information to

- Self
- Physician/Facility _____

Address _____

Purpose Medical Care Personal Other _____

Information to be Released (Please check all that apply and specify dates)

- Entire Record Clinic Visit Notes _____ Test Results _____
- Letters _____ Hospital Notes _____

DHS will not release information regarding HIV Test Results, Genetic Screening Test Results, Alcohol and Drug Abuse Records, Psychotherapy, Social Work Counseling/Therapy, Domestic Violence Victims' Counseling or Sexual Assault Counseling without specific written notification from the patient.

I understand that

- I may withdraw my authorization at any time and may be withdrawn except to the extent that action has been taken in reliance on this authorization.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected, however, the information cannot be released. I will receive a copy of this form after I sign it.
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by Digestive Health Specialists, P.C.
- I understand that the authorization will automatically expire in six months.
- If the information was sent to another person or facility, I understand that I may see and copy the information described on this form if I ask for it.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons of agencies listed above.

Patient's Signature _____ Date _____

Print Name _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required

Signature of Legal Representative _____ Date _____

Print Name _____ Relationship to patient _____