DIGESTIVE HEALTH ASSOCIATES, PC
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Authorization for Release of Information

SECTION A: MUST BE COMPLETED FOR ALL AUTHORIZATIONS

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

Date of Birth: _____ **Phone Number:** _____

Organization providing the information:	**Organization receiving the information:**
_____	_____
_____	_____
_____	_____
_____	_____

Specific description of the information (including date(s) of healthcare) to be disclosed:

If this release is granting us permission to discuss your protected health information with a friend or family member, please select one or both options below:

- ❑ Permission to speak with the friend or family member identified above
- ❑ Permission to release records to friend or family member identified above (on their specific written request)

SECTION B: MUST BE COMPLETED ONLY IF A HEALTH PLAN OR HEALTH CARE PROVIDER HAS REQUESTED THE AUTHORIZATION:

The health plan or health care provider must complete the following:

- What is the purpose or the use of the disclosure? _____
- Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?
  - ❑ Yes
  - ❑ No

The patient or the patient's representative must **read and initial** the following statements:

Initial _____ I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

Initial _____ I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it.

SECTION C: MUST BE COMPLETED FOR ALL AUTHORIZATIONS:

The patient or the patient's representative must **read and initial** the following statements**:**

Initial _____ I understand that this authorization will expire on: _____/_____/_____.

Initial _____ I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation.

_____ _____
Signature of patient or patient's representative **Date**
(*This form MUST be completed before signing***)**
Printed name of patient's representative:_____

Relationship to patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION