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Digestive Care Physicians, LLC

Gastroenterology • Hepatology • Therapeutic Endoscopy
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Date _____

Patient Name: _____

Date Of Birth: _____

Social Security No: _____

Phone Number: _____

☐ All Records ☐ History & Physical

☐ Lab ☐ US / CT/MRI

☐ Endoscopy _____

☐ Other _____

☐ Mail ☐ Pickup ☐ Fax

Purpose or need for information: _____

_____

I hereby authorize that Digestive Care Physicians, LLC

RELEASE / OBTAIN

(circle one)

the protected health information regarding the above named person to/from:

Person/Institution: _____ _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.

PROHIBITION ON RE-DISCLOSURE: Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by federal law. Federal regulation (42 CFR Part 2) prohibits recipients from making any further disclosure of this information except with specific written consent of the patient. HIV testing, ARC and/or AIDS related diagnosis is further prohibited from disclosure by State. Regulations without the specific written consent of the patient. A general authorization for the release of information if held by another party is not sufficient for this purpose.

RE-DISCLOSURE: Notice is hereby given to the patient of legal representative signing this Authorization that Digestive Care Physicians, LLC cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.

Signed _____ Witness: _____

(Patient or Legal Guardian)

_____

(Guardian's Relationship to Patient)