

DIGESTIVE HEALTH ASSOCIATES, PC
SOUTHWEST ENDOSCOPY CENTER, RLLLP
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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