**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***