

Authorization for Medical Records Release (RECORDS TO BE RELEASED FROM DHC TO PATIENT/OTHER FACILITY)

Patient Name: _____ Date of Birth: _____ SS#: _____

Address: _____ Phone #: _____

I hereby authorize Digestive Healthcare Center to release information from my medical record as indicated below TO:

Name: _____ Phone# _____

Address: _____ Fax# _____

Covering the period(s) of health care from (date) _____ to (date) _____

Information to be released:

<input type="checkbox"/> Office Visit Notes	<input type="checkbox"/> Laboratory tests (Bloodwork, Stool etc..)
<input type="checkbox"/> Procedure reports	<input type="checkbox"/> Radiology tests (U/S, C/T, MRI etc..)
<input type="checkbox"/> Pathology(Biopsy) reports	<input type="checkbox"/> Other (please specify) _____

OR

Complete Health Record (THERE IS A \$1.00/PER PAGE CHARGE FOR THIS)*

*There is no charge for records being forwarded to another facility for ongoing care or follow up treatment.

I understand that this will include information relating to (check if applicable):

<input type="checkbox"/> acquired immunodeficiency syndrome (AIDS)	<input type="checkbox"/> human immunodeficiency virus (HIV) infection
<input type="checkbox"/> behavioral health service/psychiatric care	<input type="checkbox"/> treatment for alcohol and/or drug abuse

Purpose of Disclosure: Changing of physicians Consultation/Second Opinion Continuing Care
 Legal School Insurance Worker's Compensation Other (please specify) _____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 90 days from the date signed.

The facility, its employees and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: _____ (Patient) Date: _____

_____ (or legal representative) Date: _____

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