Digestive HealthCare Center, P.A.

RELEASE OF INFORMATION FORM

Dear Patient,
This form is required to release any of your medical information to your spouse, family, friends, physicians, attorneys, etc. Please complete at least one person or specify none. Please note: if you state "None", we CANNOT release ANY information to anyone.

I hereby give permission for representatives of Digestive HealthCare Center, P.A. to release or discuss y Protected Health Information (PHI) with the following individual(s):

Relatives: Name______________________________ Date of Birth_____________________
Name______________________________ Date of Birth_____________________
Name______________________________ Date of Birth_____________________
Name______________________________ Date of Birth_____________________

Physicians: Name______________________________
Name______________________________
Name______________________________

Other: Name______________________________ Date of Birth_____________________
Name______________________________ Date of Birth_____________________

<u>COMMUNICATIONS:</u>

Please indicate how you wish us to reach you:

1st Phone # Preference:_________________________ OK to leave a detailed message?_______

2nd Phone # Preference:_________________________ OK to leave a detailed message?_______

This release of information form will be in effect until notified of the contrary. If you want this form to expire on a particular date, indicate here. Date of Expiration:______________________

PLEASE SIGN HERE:

Printed Name:_________________________________ Date of Birth:________________________

SIGNATURE:__________________________________ Date:_____________________________

Revised 3/25/09