Digestive Specialists, P.A.

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AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name: _____

Address: _____
Mailing Address **City** **State** **Zip Code**

Date of Birth: _____/_____/_____ **Social Security #:** _____--_____--_____

AUTHORIZES: **Name of Facility/Physician:** _____

Fax #: _____-_____-_____ **Phone #:** _____-_____-_____

Address: _____

City, State, Zip Code: _____

Please release the following medical information to:

Digestive Specialists, P.A.

☐ **Progress Notes** ☐ **Operative Reports** ☐ **Lab Reports** ☐ **X-Ray Reports**
☐ **Pathology Reports** ☐ **HIV Test Results** ☐ **Other (please specify)** _____

_____ **Mail** ✓ **Fax –> Fax # 936-321-0032**

Purpose of Disclosure: Medical Care
I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall ☐ **Not Expire**; or shall expire in ☐ **180 Days** from the date of my signature, unless specified in writing here: **(Please choose one of the above)**

_____
Patient's Signature

To The Party Releasing This Information:
I, the undersigned, have read the above and authorize the person or facility noted above to disclose such information as herein contained. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient any may no longer be protected. I hereby release and hold harmless the above named facility or Physician from all liability and damages resulting from the lawful release of my Protected Health Information.

_____ _____
Patient's Signature **Witness**
_____/_____/_____ _____/_____/_____
Date **Date**

*** OFFICE USE ONLY *** **This request was sent by** ☐ **Mail** ☐ **Fax on** _____
(Initials and Date)