REX Digestive Healthcare

MEDICAL RELEASE AUTHORIZATION

To: _____
Doctor or Hospital

_____
Address

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I hereby authorize and request you to release to the following:

_____
Doctor or Hospital

_____
Address

Specific information to be released: _____

_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that it I revoke this authorization, I must do so in writing and present my written revocation to the health provider identified above. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure, and that the information may no longer be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Digestive Healthcare, PA. A photocopy of the signed original of the document shall be sufficient and acceptable authorization for the release of my records.

Full Name of Patient: _____

Maiden Name if Applicable: _____ **Date of Birth:** _____

Address: _____
Street City State Zip

Signature of Patient/Guardian: _____**Date:** _____

Witness Signature: _____ **Date:** _____

Copy mailed on _____ **by** _____

Copy picked up by _____ **on** _____