



# Digestive Disease Associates

*Specialists in diagnosing and treating gastrointestinal, biliary and liver disorders*

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## **AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO DDA**

PLEASE READ THE FORM CAREFULLY AND FILL OUT COMPLETELY

### **I AUTHORIZE:**

\_\_\_\_\_  
Name of sending person/organization

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

### **INFORMATION TO BE RELEASED:**

Any information including the diagnosis and records of any treatment or examination rendered to me.

### **RECORDS FROM THE TIME PERIOD:**

\_\_\_\_\_ to \_\_\_\_\_

### **PURPOSE OR NEED FOR DISCLOSURE**

Continuity of medical care

### **AUTHORIZATION**

I understand that this authorization shall be valid for 90 Days. I understand that I may revoke this consent form at any time except to the extent that action has already been taken. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

\_\_\_\_\_  
Patient's Name (at time of treatment)

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/Zip Code

\_\_\_\_\_  
Daytime Phone Number (s)

\_\_\_\_\_  
Signature of Patient or Representative, if minor

\_\_\_\_\_  
Date

### **Please forward the information to the following office location**

- 4660 Wilkens Avenue, Ste. 206
- 4660 Wilkens Avenue, Ste. 303
- 10710 Charter Drive, Ste. 110
- 3333 N. Calvert Street, Ste. 680

My treatment with DDA is with Dr. \_\_\_\_\_