DIGESTIVE DISEASE ASSOCIATES

SPECIALIZING IN DIAGNOSING AND TREATING GASTROINTESTINAL, BILIARY AND LIVER CONDITIONS

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Digestive Disease Associates to release my medical record information including dates, history of illness, diagnostic and therapeutic treatment.

____

Patient Name

____

Street Address, City, State, Zip Code

___________________________	_____________________________	______________________________
Date of Birth	Social Security Number	Daytime Phone Number(s)

Record(s) for the period from ____________ to ________________.

Information to be released: ____

Information to be released to:

____

Name

____

Street Address, City, State, Zip Code

- In addition, to authorizing the release of records generated by Digestive Disease Associates, I authorize disclosure of medical records received from other providers. (Note: The disclosure of records furnished by other providers may be prohibited by those providers.)
- I understand this consent can be revoked in writing at any time. This revocation will not cover disclosures made previously in reliance on this consent.
- This authorization shall expire 90 days from the date noted below.
- The facility, its employees, officers and medical staff are released from legal responsibility or liability for the release of the information in accordance with this consent.

____	__________________________
Signature of Patient or Representative, if Minor	Date

____

If Representative, Name and Relationship to Patient

For Office Use Only

○ Records copied ○ Mailed ○ Ready for Pick-up ○ Faxed

Picked up by: ________________________________ ID checked Date: _____________ Initials: _____________