Allied Digestive Health

# Records Release Authorization for use and disclosure of Protected Health Information (PHI)

**I am requesting protected health information/ records to be released for the following person:**

Patient Name: _____ Birthdate: ____/____/____

Phone: ____-____-____ Maiden or other name: _____

**Please release medical records/Information from:**

Physician's Name(s): _____

Practice: _____ Phone: _____ Fax: _____

**I am authorizing the following medical information (check all that apply) be released/disclosed:**

☐ All ☐ Operative Reports ☐ Pathology Reports ☐ Lab Results ☐ Radiology Reports ☐ Hospital Records

Other, specific dates of treatment or procedures: _____

**Please forward the requested medical records/ information to:**

Name: _____ Phone: _____ Fax: _____

Address: _____

**Signature Authorization:**

- I understand that I have the right to revoke this authorization at any time.
- I understand that my revocation must be in writing and addressed to the Privacy Officer of the above named facility authorized to make this disclosure.
- I understand that the revocation does not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked this authorization will expire in two months or on this date listed _____.
- I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law.
- I understand that I need not sign this authorization to assure treatment.
- I understand that I may inspect and/or copy the information to be disclosed.
- I understand that authorizing is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the Allied Digestive Health Privacy Officer who is authorized to disclose this information and request a copy of this authorization.
- I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information or genetics. THIS INFORMATION WILL ALSO BE RELEASED UNLESS YOU INDICATE; __ DO NOT RELEASE (Indicate with a check mark).

## I understand, consent and agree to these statements:

_____ _____

Signature of Patient or Guardian Date

_____ _____

Representatives Authority to Act on Behalf of Patient Signature of Witness