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: _____