Digestive & Liver Disease Consultants, P.A.

Comprehensive Gastrointestinal & Hepatology: Consultative, Endoscopy & Motility Services

Authorization to Release Information TO Another Entity FROM DLDC

Section A: Must be completed for ALL authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

Date of Birth: _____ **DLDC Acct Number:** _____

Organization providing the information:

DIGESTIVE & LIVER DISEASE CONSULTANTS, P.A.

275 Lantern Bend Suite 200 Houston, Texas 77090

281-440-0101 Ext 1125

Fax: 855-404-4345 or

Email: MEDICALRECORDS@GIMED.NET

Provider/Person receiving the information:

Name: _____

Address: _____

Phone: _____

Fax: _____

Please ☐ MAIL ☐ FAX my records or ☐ I will pick up at Lantern Bend Office**

(****pick up is not an option if request is made out to anyone other than the patient**)

(REQUIRED) Specific description of the information (including date(s) of healthcare) to be disclosed:

_____

_____

_____

Section B: Must be completed ONLY if a patient, health plan or health care provider has requested the authorization

1. The patient, health plan or health care provider must complete the following:
   a. **What is the purpose of the use or disclosure?**

      _____

      _____

   b. Will the patient, health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? YES _____ NO_____

2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
      Initials: _____
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it.
      Initials: _____

Section C: Must be completed for ALL authorizations:

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on _____/ _____/ 2_____
   Initials: _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation.
   Initials: _____

_____ _____

Signature of patient or patient's legal representative **Date**

(This form MUST be completed before signing)

Printed name of patient's legal representative (Legal Documentation Required): _____

Relationship to the patient: _____

This form may be used to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.