CAPITAL DIGESTIVE CARE℠
First in Digestive Health

Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

Capital Digestive Care is dedicated to maintaining the privacy of your protected health information. Federal and state laws ensure the privacy of your medical records, their availability to you, and specific rights regarding your medical records. In addition to your authorization, we may use or disclose your health information in accordance with the law under certain circumstances. Please refer to our full HIPAA Notice of Privacy Practices for all potential general use and disclosures.

I UNDERSTAND MY RIGHTS TO:

Revoke or change the authorization below at any time. (Please note, revocation is not effective in cases where the information has already been disclosed but will be effective going forward from the notice to revoke). I may also inspect or copy my protected health information to be disclosed as described in this document. I understand that if the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

DISCLOSURE AND RELEASE OF PAPER OR ELECTRONIC RECORDS: (Choose and initial only **one** option)

_____ I **DO NOT** authorize the disclosure or release of my protected health information to any person/entity or via a
Initial message left on a voicemail.

_____ I authorize the physicians and staff of the practice to disclose health information regarding appointments, labs
Initial bills or other general patient communication via voicemail on the following telephone numbers:

Telephone #: _____ Telephone #: _____

_____ I authorize the disclosure or release of the following protected health information:
Initial

- ☐ All records
- ☐ Office visit notes
- ☐ Pathology Reports
- ☐ Radiology Reports
- ☐ Laboratory Reports
- ☐ Other (specify): _____

This information may be disclosed or released to: Name: _____
Relationship: _____ Address: _____
_____

This authorization expires on: ____/_____/_____ *(if no date specified, an automatic expiration occurs in one year).*

_____ _____
Signature of Patient or Representative Date
Your refusal to sign this authorization will not result in denial of treatment.

_____
Printed Name/Title of Representative