CAPITAL DIGESTIVE CARE℠
First in Digestive Health

Associates in Gastroenterology

Authorization of Release

Name of Patient: _____ Date of Birth: _____

_____ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to receive information.	**Description of information to be released.**
Check each person/entity that you approve to receive information.	Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of Lab Tests/X-Rays ☐ Other _____
☐ Spouse	☐ Financial ☐ Medical as follows: _____ _____
☐ Parent (provide name) _____	☐ Financial ☐ Medical as follows: _____ _____
☐ Other (provide name) _____	☐ Financial ☐ Medical as follows: _____ _____

PATIENT INFORMATION

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. ***This authorization shall be in effect until revoked by the patient.***

_____ Date: _____

Signature of the Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation):