DIGESTIVE DISEASE SPECIALISTS, INC

Digestive Disease Specialists, Inc.
Institute of Digestive Disease
DDSI AEC South, LLC

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____
Date of Birth: _____ Medical Record No.: _____

Type of Request (check one):

☐ I request that DDSI disclose information in my medical record to: _____
at this address: _____
for this purpose: _____

☐ I understand that DDSI requests that I authorize it to disclose information in my medical record to: _____ for this purpose _____
_____

I understand that DDSI, Inc. may assess a fee of 50 cents for each page (for paper copies) and $5.00 for x-rays and other images; for providing copies electronically, the charge is 30 cents a page up to $200.

I authorize the following information to be used or disclosed:

☐ All medical information concerning this patient from DDSI, Inc.
☐ Medical information concerning this patient from DDSI, Inc. for the following dates: _____.
☐ Other: _____.

I understand:

- DDSI, Inc. may not condition treatment on my providing this authorization for use or disclosure of my medical information. If I refuse to sign this authorization, I will still be eligible to receive medical services from DDSI, Inc.
- I have the right to revoke this authorization at any time by sending a letter to _____
_____
which gives my name and the date I signed this authorization and state that I revoke the authorization to use my medical information.
- DDSI, Inc. may disclose my medical information to a recipient who could possibly later use or disclose the information without my authorization.
- I may inspect or copy the information from my medical records that will be used by DDSI, Inc. for the purposes set forth in this authorization.
- I have the right to refuse to sign this authorization and if I refuse, my medical information will not be used by DDSI, Inc. for the purposes indicated.
- I will receive a signed copy of this authorization form.

Signature of Patient or Patient's Representative:

_____ Date _____

Description of representative's authority:

☐Parent of a minor ☐Legal guardian
☐Power of Attorney
☐Other: _____

_____
Printed name of Patient or Patient's representative

This authorization is only effective if it is signed and dated. This authorization expires one year after the date it is signed or upon the occurrence of the following event: _____.