DIGESTIVE
DISEASE
MEDICINE
OF CENTRAL NEW YORK, L.L.P.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name	Date of Birth	Phone Number
Address	City, State	Zip

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that if my health information is used or disclosed, the released information may no longer be protected by privacy regulations issued by the federal government.

Reason for Use/Disclosure of Information:

❑ Continuity of Care/Medical Treatment: ***Upcoming Appointment Date***: _____ ❑ Disability

❑ Insurance ❑ Legal Reasons ❑ Transfer of Care ❑ Other: Explain _____

Name and Address of Person/Facility Releasing Information:	**Name and Address of Person/Facility Receiving Information:**
_____	_____
_____	_____
_____	_____
_____	_____

Description of information that may be disclosed (check off the appropriate items): _____
(Date of Service)

❑ History & Physical

❑ Operative Report

❑ Laboratory Results

❑ Diagnostic Test/Results (lab, x-rays and other test results)

❑ Other (please describe)

_____

❑ Psychiatric/Mental Health Records

❑ Substance (Drug/Alcohol) Abuse Records

❑ HIV Related Records (Requires a separate signed release from)

❑ Entire Medical Record

This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. I understand that DDM will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability

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to obtain treatment or payment. I understand that, if requested, DDM will provide me with a copy of this authorization form after I sign it. Per New statute, this facility shall charge $.75 per page for copies. If a person is unable to afford such a payment, and shows proof of inability to pay, the fee will be waived.

Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

I understand that I have a right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing, and present my written revocation to the DDM Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ _____

Signature of Patient or Patient's Representative/Relationship to Patient Date

_____ _____

Signature of Witness Date