DIGESTIVE HEALTH
ASSOCIATES

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dhagastro.com/

1. AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

2. Patient Information

Name ______________________ Date Of Birth ______________________

Address: ______________________ Apt./Unit #: __________ City: __________ State: __________

Zip Code: __________ Phone Number ______________________

3. Clinic/Hospital/Health Care Provider: (Who has the information you want released?Please list the specific Hospital and / or clinic.)

Name ______________________ Address: ______________________

City: __________ State: __________ Zip Code: __________

4. Receiving Party: (Where do you want the information sent? Who may have the information?)

Address: ______________________ Name ______________________

City: __________ State: __________ Zip Code: __________ Receiving Party
☐ Me ☐ Other

5. Information To Be Released: What do you want sent or released? Check the appropriate box.)

Date(s) of Service: From __________ To __________

☐ Physician Office Medical Records ☐ Billing Records ☐ Hospital Medical Records ☐ Copies of Images

Only record types checked below:
☐ Discharge summary / note ☐ History & Physical Exam ☐ Operative report ☐ Consultations
☐ Radiology reports ☐ Laboratory reports ☐ Progress Notes ☐ Emergency records
☐ Immunization/allergy record ☐ Pathology reports
☐ Other records (Specify record type(s)______________________

6. Special Authorization Section (Per IC-16-39-2 this special authorization is valid for 180 days.)

State and federal law protect the following information. If this information applies to you, please indicate if you like this information released/obtained (include dates where appropriate)

Alcohol, Drug, or Substance Abuse Records
☐ Yes ☐ No

Genetic Records
☐ Yes ☐ No

HIV Testing and Results
☐ Yes ☐ No

7. **Release Instructions: (How and when do you want the information?)**

Release Method/Format requested:(check one)

☐ Electronic Access - Email
address
☐ ☐ Paper ☐
☐ Fax (patient care only)

8. **Purpose Of Release : (Why is it needed?)**

☐ Personal use* ☐ Insurance application* ☐ Social Security appeal ☐ Continuing Care
☐ Insurance payment/claim ☐ Litigation/legal* ☐ Social Security Disability Determination*
☐ Other*______________________________

*Fees may be charged in accordance in IN Statute 760 IAC 1-71-3 and Federal Rule 45 C.F.R. 164.524

9. * This authorization will expire in 60 days from the date signed unless otherwise specified

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* I understand that I have the 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 above named authorized entity. The revocation will not apply to information that has already been released in response to this authorization.

* I understand that I am not required to sign this Authorization in order to receive health care treatment.

* DHA records may include records that it received that it received from other organizations. If these records have been used by DHA, and filled in the record DHA maintains about you, these records may be released with your DHA records.

* DHA cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release DHA from any and all liability resulting from a re-disclosure by the recipient.

Your signature indicates that you have read and understand this form, and you authorize release of you information as described above Parent/Legal Guardian Signature

______________________________	______________________
Signature	Date