Digestive Associates

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☐ Completed
(Check box if copies already provided)

AUTHORIZATION TO ACCESS OR DISCLOSE PROTECTED HEALTH INFORMATION

Please note that each section of this form must be completed in its entirety.
Failure to specify (including dates) will delay the processing of your request.

Patient Information:

Last Name	First Name		Middle
Other/Former Names			Date of Birth / /
Phone Number	E-mail Address		
Address	City	State	Zip

Recipient of Records:

In regards to my protected medical records, I hereby authorize Digestive Associates of Ohio to disclose records to OR receive records from:

Name			
Address	City	State	Zip
Phone Number	Fax Number		

Information will be:

☐ Mailed ☐ Picked up by:_____ Relationship to patient:_____

☐ Reviewed Only ☐ E-mailed* to: (email address)_____

* Please see back of page regarding email release. Also note that email is only appropriate for sending records under 6 pages. If you are requesting entire medical records or more than 6 pages, we ask that you choose a different method of receipt.

Information to Disclose:

☐ Endoscopy/Operative Reports ☐ Pathology/Biopsy Results ☐ Discharge Summaries

☐ History & Physical Reports ☐ Laboratory Results ☐ Radiology

☐ Other:_____

Purpose of Disclosure:

☐ Changing Provider (Doctor) ☐ Second Opinion ☐ Continuity of Care

☐ Legal ☐ Personal Use ☐ Insurance

☐ Workers' Compensation ☐ School/Educational Purposes ☐ Payment

☐ Other:_____

***Email Disclosure:**

Please keep in mind that information sent via email (over the internet) is ***not secure***. While it is unlikely, it is still possible that a third party could intercept the email and therefore has access to any information sent or received, including personal information and medical records. By opting to have your information emailed to you, you are consenting to your records being sent over a non-secured network, and will not hold Digestive Associates of Ohio liable if a third party intercepts and/or disseminates this information with or without your knowledge.

Specially Protected Records

I understand that protected health information may include HIV-related information and/or information relating to diagnosis or treatment of mental illness and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

Substance Abuse (including alcohol/drug abuse)
Mental Health
HIV related information (including AIDS related testing)

1. I understand that this authorization will expire one year from the date of my signature below.
2. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations. However, other state or federal laws may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
3. I understand that refusal to sign this authorization will not jeopardize my right to healthcare and payment for my healthcare except where disclosure of my protected health information is required for the provision of healthcare or to obtain payment for healthcare.
4. I understand that I can request a copy of this form after I sign it.

A photocopy of this form will be considered as valid as the original.

By signing below I affirm that I am the patient, or the patient's representative, and have the authority to authorize who may access this patient's health information and to review and/or request changes to this patient's health information.

Signature_____ Date/Time: _____

Relationship to Patient, If not Patient _____ Date/Time: _____