



Digestive Disease Associates

Specialists in diagnosing and treating gastrointestinal, biliary and liver disorders

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CONSENT FOR RELEASE OF INFORMATION

I hereby authorize Digestive Disease Associates to release my medical record information including dates, history of illness, diagnostic and therapeutic treatment.

Patient Name

Street Address

City, State Zip Code

Birthdate

Social Security Number

Daytime Phone Number(s)

Record(s) for the period from _____ **to** _____.

Information to be released: _____

Information to be released to:

Name

Address

City/State/Zip Code

- In addition, to authorizing the release of records generated by Digestive Disease Associates, I authorize disclosure of medical records received from other providers. (Note: The disclosure of records furnished by other providers may be prohibited by those providers.)
- I understand this consent can be revoked in writing at any time. This revocation will not cover disclosures made previously in reliance on this consent.
- This authorization shall expire 90 days from the date noted below.
- The facility, its employees, officers and medical staff are released from legal responsibility or liability for the release of the information in accordance with this consent.

Signature of Patient or Representative, if Minor

Date

If representative, name and relationship to Patient

For office use only

- Records copied Mailed Ready for Pick-up Faxed

Picked up by: _____