Digestive & Liver Disease Consultants, P.A.

Comprehensive Gastrointestinal & Hepatology: Consultative, Endoscopy & Motility Services

Authorization for Release of Information FROM Another Entity TO DLDC

Section A: Must be completed for ALL authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

Date of Birth: _____/_____/_____ **Account Number:** _____

Organization to provide the requested information.

_____

_____

_____

DIGESTIVE & LIVER DISEASE CONSULTANTS,PA
275 Lantern Bend Drive Ste. 200
Houston, Texas 77090
Phone: _____ ***Fax: 855-404-4345***

Specific description of the information (including date(s) of healthcare) to be disclosed:

_____

_____

Section B: Must be completed ONLY if a health plan or health care provider has requested the authorization

1. The health plan or health care provider must complete the following:

a. What is the purpose of the use or disclosure?

_____

b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? YES _____ NO _____

2. The patient or the patient's representative must read and initial the following statements:

a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
Initials: _____

b. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it.
Initials: _____

Section C: Must be completed for ALL authorizations:

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on _____/ _____/ ____ (1Year from signature date)
Initials: _____

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation.
Initials: _____

_____ _____/__/____

Signature of patient or patient's representative *(This form MUST be completed before signing)* *DATE*

Printed name of patient's representative: _____

Relationship to the patient: _____

This form may not be used to release information for treatment or payment
except when the information to be released is psychotherapy notes or certain research information.

Alternate Fax: 281-440-0526 Requesting Provider : GNR / LP / HBH / NK / CD / KB Assistant: _____