ASSOCIATES IN DIGESTIVE HEALTH

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AUTHORIZATION TO OBTAIN MEDICAL RECORDS

I, **[name of patient]** _____, authorize Associates in Digestive Health to obtain medical records, including any HIV (AIDS) information from_____ for continuation of care.

Phone: _____ Fax: _____

ADH Patient Number: _____ Date of Birth: _____

Fax Number of Associates in Digestive Health: 239-772-5073

Please send the following information:

_____ Entire Record except psychotherapy notes
_____Pathology report
_____Operative report
_____Emergency and urgent care records
_____EKG
_____ Hospital Record
_____Radiology Report
_____ Labs
_____ Office Notes
_____ Other_____

This authorization is for the listed date(s) of treatment:
From: _____ To: _____

Special Instructions: _____

This authorization to obtain records will expire on _____. If an expiration date is not written it will expire one year from the date signed below.

By signing below I authorize the use or disclosure of my individually identifiable health information as noted above. I have been made aware that if the receiver re-discloses my information, it may no longer be protected by federal privacy regulations, and that Associates in Digestive Health is not liable for any consequences of such re-disclosure. I understand that I may revoke this authorization at any time by notifying Associates in Digestive Health compliance officer in writing, but the revocation will not affect any actions which Associates in Digestive health may have taken prior to the receipt of the written revocation.

Patient Signature: _____ Date: _____

Legal Representative: _____ Relationship: _____