

DIGESTIVE DISEASE SPECIALISTS, INC.

Larry A. Bookman, MD
Trenton F. Horst, DO
Ross S. Keener, MD
Paul N. Maton, MD
Sikandar A. Mesiya, MD
Don P. Murray, MD

David A. Neumann, MD
Baolong Nguyen, MD
Son H. Nguyen, MD
Barry G. Perkins, MD
Carl A. Raczkowski, MD
Robert A. Rankin, MD

Arun K. Sachdev, MD
Kenneth A. Seres, MD
Dan W. Smith, MD
David A. Stokesberry, MD
Clinton G. Wallis, MD
Robert L. Wilson, MD

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Social Security #: _____

Date of Birth: _____

Medical Record #: _____

Type of Request (check one):

I understand that DDSI is requesting that I authorize disclosure of my medical record to:

_____ for this purpose _____

I am requesting that DDSI disclose information in my medical record to: _____

at this address: _____ for this purpose _____

I understand that DDSI may assess a fee of \$1.00 for the first page and .50 for each additional page, and \$5.00 for x-rays and other images.

I am authorizing the following information be used or disclosed (check one):

All medical information from DDSI concerning this patient.

Medical information concerning this patient from DDSI for the following dates: _____

Other: _____

I understand:

- That DDSI may not condition treatment on my providing this authorization for use or disclosure of my medical information. If I refuse to sign this authorization, I will still be eligible to receive medical services from DDSI.
- I have the right to revoke this authorization at any time by sending a letter to _____, which gives my name and the date I signed this authorization, and states that I revoke the authorization to use my medical information.
- DDSI may disclose my medical information to a recipient who could possibly later use or disclose the information without my authorization.
- I may inspect or copy the information from my medical records that will be used by DDSI for the purposes set forth in this authorization.
- I have the right to refuse to sign this authorization, and if I refuse, my medical information will not be used by DDSI for the purposes indicated.
- I will receive a signed copy of this authorization form.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

Signature of Patient
or Patient's Legal Representative

Date

Printed Name of Patient
or Patient's Representative

Description of Representative's Authority:

Parent of a Minor Legal Guardian

Power of Attorney Other: _____

This authorization is only effective if it is signed and dated. This authorization expires one year after the date it is signed, or upon written revocation from the patient or patient's representative, or upon the occurrence of the following event:
