

**DIGESTIVE DISEASE SPECIALISTS, INC.  
INSTITUTE OF DIGESTIVE DISEASE  
DDSI AEC SOUTH, LLC**

**AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF  
HEALTH INFORMATION**

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Social Security No.: \_\_\_\_\_  
Medical Record No.: \_\_\_\_\_

**Type of Request (check one):**

I understand that DDSI, Inc. is requesting that I authorize it to disclose information in my medical record to: \_\_\_\_\_ for this purpose: \_\_\_\_\_.

I am requesting that DDSI, Inc. disclose information in my medical record to: \_\_\_\_\_ at this address \_\_\_\_\_ for this purpose \_\_\_\_\_.

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

**I am authorizing the following information to be used or disclosed:**

All medical information concerning this patient from DDSI, Inc.

Medical information concerning this patient from DDSI, Inc. for the following dates: \_\_\_\_\_.

Other: \_\_\_\_\_.

**I understand:**

- DDSI, Inc. 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, Inc.
- 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, Inc. 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, Inc. 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, Inc. 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, 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  
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 the occurrence of the following event: \_\_\_\_\_.

BMSI (405) 685-0177  
DDSI - Form# R-0104

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