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www.OptimalDigestiveCare.com

1. I AUTHORIZE:

Optimal Digestive Care

2. RELEASE TO:

Name of receiving person/organization

Street

City State Zip Code

3. INFORMATION TO BE RELEASED: (CHECK ALL APPLICABLE)

All Radiology Reports
All Pathology Reports
All Office Notes

All Procedure Reports
All Lab Results
Other:

ENTIRE MEDICAL RECORD

SPECIAL AUTHORIZATION: CHECK APPLICABLE BOX(ES) AND SIGN IMMEDIATELY BELOW.

BY SIGNING BELOW, I AM AUTHORIZING THE OFFICE TO RELEASE ANY AND ALL INFORMATION REGARDING:

ALCOHOL
DRUGS

MENTAL HEALTH
SEXUALLY TRANSMITTED DISEASES

HIV
AIDS

NOTE: If this release pertains to alcohol, drugs, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rule prohibits you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: Date:

4. RECORDS FROM THE TIME PERIOD (Please check one of the two options below)

For the following time period: through
No time period specified

5. PURPOSE OF DISCLOSURE: (MUST BE COMPLETED)

TRANSFER: Yes No
Reason: Payment of Insurance Claim Legal
Worker's Compensation Claim Other:

6. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time, except to the extent that action has already been taken.

7. The requestor may be provided with a copy of this authorization form, if it is requested.

PRINT NAME:

PATIENT SIGNATURE: DATE:

DATE OF BIRTH: PHONE #: