THE CENTER FOR
Digestive & Liver Health
and The Endoscopy Center

- ☐ Brent Acker, MD
- ☐ George Aragon, MD
- ☐ Steven Carpenter, MD
- ☐ Rodney Cohen, MD
- ☐ Charles Duckworth, MD
- ☐ Mark Murphy, MD
- ☐ Mark Nyce, MD
- ☐ Madeline Russell, MD
- ☐ Edward Rydzak, MD
- ☐ Ryan Wanamaker, MD

AUTHORIZATION FOR RELEASE/RECEIVE INFORMATION

I hereby authorize *The Center for Digestive & Liver Health* and/or *The Endoscopy Center* to release/receive information from the health record of:

Patient Name _____ SSN _____-____-_____ DOB ___/___/___

Address _____ City _____ State _____ ZIP _____

Telephone Number _____

To be: ☐ Sent To ☐ Received From ☐ To Discuss With

Name _____ Phone Number _____ Fax Number_____

Address _____ City _____ State _____ ZIP _____

Information to be released (check all that apply)

- ☐ Entire Record
- ☐ Lab Results
- ☐ Radiological Results
- ☐ Nursing Notes
- ☐ Physician Orders
- ☐ Pathology Results
- ☐ Pathology Blocks
- ☐ Pathology Slides
- ☐ Medical Admin Record
- ☐ Demographic Information
- ☐ Dictated Reports (H&P, Discharge Summary, OP note, consults, test results, etc.)
- ☐ Other _____

for dates of services rendered from _____/_____/_____ through _____/_____/_____

for the purpose of _____

I understand that I can revoke this authorization by providing written notice to The Center for Digestive and Liver Health and/or The Endoscopy Center at the address listed above or in a manner described in the Notice of Privacy Rights. I also understand that if information has been released by relying upon this authorization, that revocation will not be valid.

I PLACE NO LIMITATION ON HISTORY OF ILLNESS OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS, MENTAL ILLNESS OR RETARDATION AND ACQUIRED IMMUNE DEFICIENCY (AIDS) SYNDROME. The Center for Digestive and Liver Health and/or The Endoscopy Center may not condition treatment or payment on the signing of this authorization unless allowed by law.

I understand that I am waiving my rights to privacy by releasing my medical information to the party listed above and this information may be redisclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above.

I understand that this Release of Information will expire within ninety (90) days from the date listed below.

Patient Signature _____ Date _____

Patient's Guardian or Capacity _____ Date _____

Relationship to Patient _____

Request Taken by _____ Date Completed _____

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