D I G E S T I V E H E A L T H C L I N I C, L L C

I D A H O E N D O S C O P Y C E N T E R, L L C

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please print and complete one form for **EACH** request. All sections must be completed in **FULL** otherwise the form will be returned for completion.

PATIENT INFORMATION:

Patient Full Name:		Date of Birth:	
Address:		City:	State:
Zip Code:	Telephone: ( )	Previous Last Name:	

I HEREBY AUTHORIZE:

Digestive Health Clinic, LLC
6259 W Emerald St.
Boise, ID 83704
Phone: 208-489-1900
Fax: 208-375-5286

CHECK ONE BOX:

☐ To **release** (send)

☐ To **request** (receive)

my confidential health information

Name:		
Address:		
City:		
Phone: ( )	State:	Zip Code:
Fax: ( )		

USE AND DISCLOSURE OF THE FOLLOWING RECORDS:

Check all that apply:

☐ Colonoscopy & related pathology report, if any

☐ EGD & related pathology report, if any

☐ Procedure report _____ (Type)

☐ Office visit

☐ Lab reports

☐ Radiology reports

☐ Pathology reports

☐ Billing (charges, payments)

Other _____

For date(s) of service:

☐ Specified date: _____/_____ /_____

☐ Past 6 months

☐ Past 1 year

☐ Past 3 years

☐ Past 5 years

☐ Past 10 years

FOR THE FOLLOWING PURPOSE(S):

☐ To provide treatment / continuity of care

☐ Request of the patient

☐ Request of the legal representative

Other _____

IN THE FOLLOWING FORMAT:

Paper

☐ Fax

☐ Mail

☐ Patient to pickup

☐ Pickup by person below

_____ (Name)

CD

☐ Mail

☐ Patient to pickup

☐ Pickup by person below

_____ (Name)

☐ **Patient portal**

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE AUTHORIZED OR ON THIS SPECIFIED DATE: _____/_____ /_____

My authorization is given freely with the understanding that:

- I understand that the Digestive Health Clinic, LLC or other health care providers may not condition my treatment on provision of this authorization unless the authorization is for the use or disclosure of information for research-related treatment, or unless the treatment is solely or the purpose of disclosing information to a third party (e.g. an employment physical).
- I understand that I may revoke this authorization at any time unless the Digestive Health Clinic, LLC or other health care provider has taken action in reliance of the authorization. To revoke the authorization, I must submit a written request to: Digestive Health Clinic, LLC Attn: Privacy Officer 6259 W Emerald St. Boise, ID 83704 Fax: 208-375-5286
- I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by applicable law.

Patient or Legal Representative Signature:	**Date:**
Printed Name:	**If legal representative, describe authority:**

OFFICE USE

_____ Name of employee assisting patient with form (please print)	**We are requesting records** Request was faxed / mailed on Date: _____/_____ /_____ by: _____	**We are disclosing records** Processed in the designated format on Date: _____/_____ /_____ by: _____

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