Digestive Health Clinic, LLC

Authorization for Disclosure of Protected Health Information

Name of Patient: _____ DOB: _____

I hereby authorize the use or disclosure of protected health information as describe below:

1) The Digestive Health Clinic and its affiliated physicians or employees may disclose the information to:
   a. Name of facility and/or provider:_____
   b. Address of facility:_____
   c. Phone and fax number of facility: _____
   d. Self or family member/other (specify):_____

OR

The Digestive Health Clinic and its affiliated physicians or employees may receive and use information from:

   a. Name of facility and/or provider:_____
   b. Address of facility:_____
   c. Phone and fax number of facility:_____

2) Specific information to be used or disclosed (check one):
   - ☐ Psychotherapy notes (cannot be combined with another authorization)
   - ☐ Medical Records (describe, including dates):_____
   - ☐ Oral Communications
   - ☐ Other (describe):_____

3) Purpose for use or disclosure (check one):
   - ☐ The use or disclosure is at the request of the individual.
   - ☐ The use or disclosure is for marketing purposes. The health care provider will/will not **(circle one)** receive remuneration from a third party for the use or disclosure of information.
   - ☐ Other (describe the purpose):_____

4) This Authorization will expire on the following date or event (check one)
   - ☐ One year from the date of the authorization
   - ☐ Other (Specify):_____

5) Requested format of disclosure (check one):
   - ☐ CD ☐ Paper ☐ Patient Portal

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: Health Information Manager
6259 W. Emerald Street
Boise, Idaho 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 personal representative:_____ Date:_____

If personal representative, describe authority type: _____

Office Use

Faxed Date:_____ Patient Pick up (date and Initial): _____

Faxed By:_____ Records prepared by: _____
(for patient pickup)