AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please print. All sections must be completed in **FULL** otherwise the form will be returned for completion.

SECTION 1 **PATIENT INFORMATION:**

Patient Full Name:		Birthdate:
Address:	City:	State:
Zip Code:	Phone: ( )	Previous Last Name:

SECTION 2 **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: If you have multiple request, complete a separate form for each request.

☐ To **send** me a copy of my records. Please use the address listed above in the patient information section.

☐ To **request (obtain)** my confidential health information from the location listed below.

☐ To **send** my confidential health information to the location listed below.

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

SECTION 3 **USE AND DISCLOSURE OF THE FOLLOWING RECORDS:** Check all that apply & complete additional detail, i.e. type of report, if needed.

☐ All colonoscopy & related pathology reports, if any

☐ All EGD & related pathology reports, if any

☐ All ERCP/EUS & related radiology & pathology reports, if any

☐ Procedure report _____ (Type)

☐ Office visit

☐ Lab reports _____

☐ Radiology reports _____

☐ Pathology reports _____

☐ Billing (charges, payments)

☐ Other (specify) _____

SECTION 4 **SERVICE DATES:** ☐ All service dates for colonoscopies, EGD's, ERCP/EUS and related pathology reports

All other reports as specified: Date Range: _____/_____ /_____ to _____/_____ /_____ or

for the past ☐6 months ☐1 year ☐3 years ☐5 years ☐10 years

SECTION 5 **RELEASE FORMAT:** ☐ Hard copies (paper) ☐ CD (requires PDF viewing capabilities)

SECTION 6 **DELIVERY METHOD:** ☐ Mail ☐ Fax ☐ Pickup by (Name) _____ ☐ Patient portal

SECTION 7 **RELEASE PURPOSE:** ☐ Personal use ☐ To provide treatment / continuity of care ☐ Request of the legal representative

☐ Other _____

SECTION 8 **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.

SECTION 9 **Signature of** ☐ Patient ☐ Legal Representative **Date: _____/_____ /_____**

Printed Name: **If legal representative, describe authority:**

OFFICE USE

_____ Name of employee who received this form from the patient (please print)	**We are requesting records:** This request was faxed / mailed on date: _____/_____ /_____ By Name: _____	**We are disclosing records:** Processed in the designated format on date: _____/_____ /_____ By Name: _____