Authorization for Release of Medical Information

Patient Name: _____ **DOB**: _____

Address: _____ **SSN**: xxx-xx-_____

Please forward copies of requested records to:

Digestive Disease Specialists
Dr. Richard Pleva & Dr. Angela Wang
5350 Distinction Way
Prescott, AZ 86301

Phone: 928-445-4066
Fax: 928-445-4345
PO Box 11654
Prescott, AZ 86304

Release the following:

- ☐ Entire Health Record
- ☐ Immunization Records
- ☐ Colonoscopy and Pathology Reports
- ☐ EGD and Pathology Reports
- ☐ Labs and Radiology
- ☐ Specific Dates of Treatment: _____
- ☐ Other: _____

I am requesting that this protected information be released for the following reason:

NOTE: "At the request of the individual" is all that is required if you do not desire to state a specific purpose.

- ☐ This request is being made because I am transferring care to another provider or leaving the area.
- ☐ This authorization shall remain in effect until _____, at which time it expires.
- ☐ I also authorize the release of information regarding assessment, diagnosis, and treatment of alcohol and/or substance abuse.
- ☐ I also authorize the release of information regarding the diagnosis and/or treatment of AIDS or HIV.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Digestive Disease Specialists: Attention Medical Release Correspondent, at the above address.

I hereby authorize Digestive Disease Specialists to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by this rule.

THERE MAY BE A SERVICE CHARGE FOR THE COPYING OF RECORDS

Patient Name: _____ **Phone**: _____

Patient Signature: _____ **Date**: _____

Legal Representative: _____ **Date**: _____
Relationship to Patient: _____