# DIGESTIVE MEDICINE ASSOCIATES—AUTHORIZATION FORM

Patient Last Name: _____ First Name: _____

SS #: _____ D.O.B. :_____ Telephone: _____ I hereby authorize you to use or disclose the specific information described below, only for the purpose and recipient described below: (Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as: date of service, type of service provided, level of detail to be released, origin of information, etc.)

_____

_____

**Recipient of Information:** _____

Name of Entity / Provider

**Ph: (305) 822.4107** 2140 West 68th Street, Suite 305

Street Address

**Fax: (305 822.5086** Hialeah, FL 33016-1815

City, State, Zip

This Protected Health Information is being used disclosed for the following purposes:

☐ Insurance ☐ Continued Treatment ☐ Legal ☐ At the Request of patient or representative

☐ Other (Specify): _____

How would I like the records to be released?

☐ Paper Copy ☐ Electronic Copy (i.e., Email) ☐ Fax _____

☐ Mailed ☐ Picked up by _____

This Authorization shall be in force and effect from the date signed below until _____ _ (specify date) or _____ (event that relates to the patient or the purpose of the use or disclosure) at which time this Authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to Privacy Office at 2140 W 68th St, Suite 305, Hialeah, FL 33016. I understand that a revocation is not effective to the extent that Digestive Medicine Associates has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Digestive Medicine Associates will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide Authorization for the request use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law) To the extent the sate law provides greater access rights.
- Refuse to sign this Authorization The use or disclosure requested under this Authorization may result in direct or indirect remuneration to the Digestive Medicine Associates from a third party.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Description of Legal Representative's Authority Date