Digestive Disorders Associates

PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN MY HEALTH CARE

☐ I GIVE PERMISSION for **Digestive Disorders Associates** to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below who are involved in my health care:

Name:_____ **Name:** _____

Relationship:_____ **Relationship:** _____

Name:_____ **Name:** _____

Relationship:_____ **Relationship:** _____

☐ I DO **NOT** GIVE PERMISSION for **Digestive Disorders Associates** to disclose relevant health information (my health status, treatment, and payment arrangements) to family members and other individuals involved in my health care.

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1. I understand that this authorization will expire one (1) year after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying DDA in writing.

Patient's Signature:_____ **Date:** _____

Patient's Printed Name: _____

* Patient is a minor (____years of age) *OR is unable to give permission because: _____

_____

Signature of Individual Signing on Behalf of Patient:_____**Date:** _____