AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name _____ Birth date (Mo/Day/Yr) _____

Street Address _____ Social Security Number _____

City, State, Zip code _____ Phone _____

I authorize Digestive Disorders Associates to release my medical records as specified below:

____All Medical Records ____Office visit notes ____Bravo/Capsule Endoscopy/Remicade
____Laboratory Reports ____ Radiology Reports ____Colonoscopy/EGD/EUS/ERCP Report
____Pathology Reports ____Other (specify)_____

Service Date(s):For the last:_____ 5 years _____2 years ____6 Months ____Other_____year(s)/month(s)
OR From _____ to _____

___I do ___I do NOT authorize release of information related to AIDS(Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

REASON FOR REQUEST
___Referral to Specialist ___Insurance ____Workers Comp ___Legal Investigation
___Disability Determination ___Personal ____Out of State Move ___Change GI Dr
___Other (specify)_____

Name of Individual or Organization: _____
Street Address: _____
City, State, Zip Code: _____

DELIVERY METHOD: (please ✓one)
__Mail to patient

__Mail to organization/individual address listed above

I understand I have the right to revoke this authorization at any time and that I must do so in writing and present my written authorization to Digestive Disorders Associates. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand my revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise specified, this authorization will automatically expire in one year.

I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand any disclosure of my information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Privacy Officer for Digestive Disorders Associates at 410-224-4887.

_____ _____
Signature of patient, guardian or Personal Representative of patient's estate — Date

NOTE:Per Maryland law, Health-General Article Section 4-304(c)(3) as of 2004 physicians are allowed to charge specific sums for and production of medical records that is adjusted annually for inflation. Please refer to MedChi.org for current fee amounts.