

**Digestive Disease Consultants**

**A Division of Arizona Digestive Health, P.C.**

**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

**NOTICE:**

- Federal law says that Digestive Disease Consultants (DDC) cannot share your health information without your permission except in certain situations. If you sign this form, you are giving DDC permission to share your health information that DDC has with the person(s)/entity you indicate below.
- This authorization is voluntary.
- Right to revoke: If you decide you do not want DDC to share your health information any longer, please sign at the end of this form and give this form to DDC.
- DDC cannot promise that the person(s)/entity you permit DDC to share your health information with will not share your health information with someone else you may not want to have your health information.
- You can keep a copy of this authorization, and can contact DDC to get a copy if you do not have one.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I give permission to: **Digestive Disease Consultants** to share my health information with

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

so that this person(s) or entity may assist me with my health care issues.

I want DDC to share this health information: **(check all that apply)**

- All of my health information
- Information regarding treatment for alcohol and /or substance abuse
- Other: \_\_\_\_\_

**This form must be signed by EITHER the patient OR by the personal representative.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

May we leave messages regarding test results and appointments on your answering machine?  Yes  No

On your e-mail?  Yes  No If yes, e-mail address: \_\_\_\_\_

Would you like us to send a text message if there is an anticipated delay in your appointment time?  Yes  No

If yes, cell number: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ .

**REVOCAION OF AUTHORIZATION**

**I no longer want DDC to share my health information with the person/entity indicated below.**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_