

**CAROLINA DIGESTIVE HEALTH ASSOCIATES, PA
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Patient Name _____ DOB _____ SS# _____

Address _____ Phone _____

I _____ hereby authorize Carolina Digestive Health
(Patient or Personal Representative)
Associates, PA, to disclose specific health information from the records of the above named patient to:

(Name and phone number of the person that the records will be sent to.)

(Fax number or complete address that the records should be sent to. We will not fax records to a patient's home or work.)

(Additional address space, if needed.)

for the specific purpose(s) of: _____

Specific information to be disclosed (please check appropriate items):

____ Office Visit Notes ____ Operative Reports ____ Pathology Reports ____ Test Results (Labs, X-rays, Etc.)

Date(s) of Service to be disclosed: _____ to _____

I understand that this authorization will expire on the following date, event or condition: _____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given. I further understand that I may request a copy of this signed authorization.

(Signature of Patient)

(Date)

(Witness-If Required)

(Signature of Personal Representative)

(Date)

(Personal Representative Relationship/Authority)

NOTE: This Authorization was revoked on

(Date)

(Signature of Staff)

Billingsley patients will be billed a small fee by Smart Corporation for the copies. The copies of these records will be mailed to you upon Smart's receipt of payment.