## Authorization for Digestive Disease Associates to Use or Disclose My Health Care Information

Patient name: ______________________________ Date of birth: ______________

Previous name: ______________________________ Patient Number: ____________

**I. My Authorization** (must complete all sections below)

**You may use or disclose the following health care information (check all that apply):**

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition: ______________________________
- ☐ Health care information in my medical record for the date(s): ______________________________
- ☐ Other (e.g., X rays, bills), specify date(s): ______________________________

**You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):**

☐ HIV (AIDS virus) ☐ Sexually transmitted diseases ☐ Drug and/or alcohol use

**You may disclose this health care information from / to:**

Name (or title) and organization: ______________________________

Address: ______________________ City: ______________ State: ________ Zip: __________

Phone: ______________________ Fax: ______________________

**And disclose this health care information from / to:**

Name (or title) and organization: Digestive Disease Associates, Ltd.
1011 Reed Avenue Suite 300 Wyomissing PA 19610
Phone: 610-374-4401 Fax: 610-374-7140

**Reason(s) for this authorization (check all that apply):**

- ☐ at my request ☐ other (specify) ______________________________
- ☐ check only if Digestive Disease Associates requests the authorization for marketing purposes
- ☐ check only if Digestive Disease Associates will be paid or get something of value for providing health information for marketing purposes

**This authorization ends:** ☐ in 60 days (standard) ☐ on (date): ______________

☐ when the following event occurs: ______________________________

A photocopy of this instrument may be used instead of the original.

**II. My Rights**

- I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:
  - To take part in a research study or
  - To receive health care when the purpose is to create health care information for a third party.
- I may revoke this authorization in writing at any time. If I did, it would not affect any actions already taken by Digestive Disease Associates based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
  - Fill out a revocation form (a form is available from Digestive Disease Associates) or
  - Write a letter to Digestive Disease Associates.
- I understand that there is a risk that the person or organization receiving my health care information could possibly redisclose it without my authorization.

______________________________ ______________________________

Patient or legally authorized individual signature Date Time

______________________________ ______________________________

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)