COLON AND DIGESTIVE HEALTH SPECIALISTS, LLC
1805 Honey Creek Commons Ste. B, Conyers, GA 30013
Phone: (770) 922-7000; Fax: (770) 809-3667/(770) 922-8070

Authorization for Use/Release of Health Information:

(This form applies only to the release and disclosure of information. It is not a consent for treatment or intended for any other purposes.)

By signing this form, I authorize Colon and Digestive Health Specialists, LLC to obtain the protected health information described below:

Name and address of Person and /or Organization to whom information should be obtained from:

_____

_____

_____

Purpose of disclosure (at request of patient, employment, life or disability insurance, etc.)

_____

I authorize the following information to be obtained from the address above:

___ Copies of all medical records for the period of ____ /____/_____ to ____ /____/_____

___ Copies of the information described below for period of ____ /____/_____ to ____ /____/_____

___ History & Physical Exam ___ Lab, X-ray, etc. Reports ____ Reports from Other Physicians

___ Other (Please Specify) _____

I hereby request that the following information not covered by a general release also be released:

___ Drug & Alcohol Records ___ Psychotherapy Records ___ AIDS/HIV records

I understand that there may be information in these records that I would not want released. The following information should not be released, even if occurring during dates above:

_____

** Please describe any special requirements such as faxing, mailing extended expiration date and the like:

_____

I understand that the Notice of Privacy Practices and I understand that Colon and Digestive Health Specialist, LLC assumes no responsibility for the use of or misuse by other of my health information disclosed under this authorization. I release Colon and Digestive Health Specialist, LLC from all legal liability that may arise from this authorization.

Patient Signature: _____ Date: _____

SS#: _____ DOB: _____ Printed Name: _____

If the signature above is not that of the patient, I am acting for the patient because _____
My relationship to the patient is: _____ Signed: _____

The patient or their representative may revoke this authorization by notifying, in writing, the office of Colon and Digestive Health Specialist, LLC. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subjected to redisclosure by the recipient. This release will expire one year after day signed or if revoked by the patient.