DIGESTIVE SPECIALISTS, P.A.

Lynn R. Copeland, MD, FACP, FACG ~ Abraham Winkelstein, MD, MS, FACP, FACG
~Anna M. Gonzales, MD ~ A. Tarkan Dural, MD, FACG ~
Ilyas M. Memon, MD ~ Edward S. Xavier, MD

Patient Name____

In accordance with the Medical Privacy Act of Texas, the physicians and/or staff of Digestive Specialists, P.A. are unable to release any information pertaining to your condition, treatment and/or care without your consent. If you authorize us to release information regarding your care to anyone other than yourself, please complete the following authorization.

I hereby authorize the physicians and/or staff of Digestive Specialists, P.A. to release information pertaining to my condition and/or care to the individuals listed below.

____
Name Relationship

____
Name Relationship

PREFERRED PHONE NUMBER (____)____________________

☐ OK to leave message on machine with detailed message

____ ______________
Signature of Patient or Patient's Representative Date

CONSENT FOR RELEASE OF INFORMATION

I hereby acknowledge that I received a copy of the Notice of Privacy Practices. I authorize Digestive Specialists P.A. to use and/ or disclose my health information for treatment, payment, and health care operations.

____ ______________
Signature of Patient or Patient's Representative Date

FINANCIAL POLICIES

I acknowledge that I received and understand the terms and conditions set forth in the Digestive Specialists P.A. Financial Policies.

____ ______________
Signature of Patient or Patient's Representative Date