

## Digestive Specialists, P.A.

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### AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

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

Address: \_\_\_\_\_  
Mailing Address
City
State
Zip Code

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

**Authorizes:      Digestive Specialists, P.A.**

111 Vision Park Blvd., Suite 150       800 Peakwood, Suite 6H  
 Shenandoah, Texas 77384      Houston, TX 77090

To release the following information to:

Name of person/facility: \_\_\_\_\_

Address: \_\_\_\_\_  
Mailing Address
City
State
Zip Code

Progress Notes       Operative Reports       Lab Reports       X-Ray Reports  
 Pathology Reports       HIV Test Results       Other (please specify) \_\_\_\_\_

Records of care from the following dates: \_\_\_\_\_ to \_\_\_\_\_  
 \_\_\_ Mail Records      \_\_\_ Fax Records # \_\_\_\_\_

Purpose of Disclosure:       Medical Care       Insurance  
     Attorney       Other (please specify) \_\_\_\_\_

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall  **not expire**; or shall expire in  **180 days** from the date of my signature, unless specified in writing here.  
(Please choose one of the above.)

\_\_\_\_\_  
**Patient's Signature**

**To The Party Receiving This Information:**

I, the undersigned, have read the above and authorize the person or facility noted above to disclose such information as herein contained. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility or Physician from all liability and damages resulting from the lawless release of my Protected Health Information.

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**

\_\_\_ Patient notified by \_\_\_ fax, \_\_\_ mail, or in \_\_\_ Office of Record Charge Policy. \_\_\_ Staff Initials