DIGESTIVE HEALTH SPECIALISTS-AZ
8573 E. Princess Drive, Suite 215
Scottsdale, AZ 85255
Phone: (480) 563-5757 Fax: (480) 513-2443

Authorization for the Release of Protected Health Information

I hereby request and authorize to **Release Information From**	*I hereby request and authorize to* **Release Information To**
□ Digestive Health Specialists Arizona 8573 E. Princess Drive, Suite 215 Scottsdale, AZ 85255	□ Digestive Health Specialists Arizona 8573 E. Princess Drive, Suite 215 Scottsdale, AZ 85255
□ Other (Specify facility/individual, address, phone & fax information below) Name:_____ Address:_____ City, State & Zip Code: _____ Phone: _____ Fax: _____	□ Other (Specify facility/individual, address, phone & fax information below) Name:_____ Address:_____ City, State & Zip Code: _____ Phone: _____ Fax: _____

Purpose of Release:

□ Personal Use □ Attorney □ Insurance
□ Further Medical Care □ Disability Determination □ Other: _____

Specific Information to be Released:

□ Clinic/Progress Notes □ Laboratory Reports □ Radiology Reports
□ Procedure/Operative Reports □ Other: _____

I understand that by signing this authorization, my consent is given to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.

I understand that I have the right to request that Digestive Health Specialists restricts how my individually identifiable health information is used and/or disclosed. I understand that Digestive Health Specialists does not have to agree to such restrictions, but once such restrictions are agreed to, Digestive Health Specialists must adhere to such restrictions.

I understand that I may revoke this authorization; the exceptions to my right to revoke and a description of how I may revoke the authorization are described in the Notice of Privacy Practices of Digestive Health Specialists, a copy of which I have been given access to receive and review.

I understand that once this protected health information is disclosed, the recipient may not be required to maintain the confidentiality of my health care information under this Privacy Rule.

This authorization does not affect my care, treatment, payment, enrollment, or eligibility for benefits with Digestive Health Specialists.

Patient Name (Print): _____
(List any previous names if applicable)

Patient Date of Birth: _____ **Patient Social Security Number**: _____

Patient Signature: _____ **Date**: _____

*If this authorization is signed by a personal representative of the individual referenced above, the representative's authority to act for the individual is as follows: _____

This authorization expires 90 days after the date it is signed.