Digestive & Liver Disease
SPECIALISTS

885 Kempsville Rd., Suite 114 Norfolk, VA 23502

Phone 757-466-0165 Fax 757-466-9082

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS OR MEDICAL INFORMATION

Patient Name **DOB** **SS#(last 4)** **Acct#**

Requesting records *from* Dr or Facility (first and last name/phone#) _____

Send records *to* Dr. or Facility (first and last name/phone#):_____

Specific information to be released_____

I am requesting that this protected information be released for the following reason:

- ☐ **This request is being made for the continuity of my care.**
- ☐ **This request is being made for my own personal use or storage.**
- ☐ **This request is being made because I am transferring care to another provider or leaving the area.**
- ☐ **I also authorize for the release of information regarding assessment, diagnosis, and treatment of alcohol, substance abuse and/or treatment of AIDS or HIV.**
- ☐ **This authorization shall remain in effect until _____ (up to 1 year) at which time this authorization expires.**

I hereby authorize the use or disclosure of my protected health information as described above.

I understand that this authorization is voluntary. I understand that ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness-for-duty evaluation or a research-related treatment.

I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be redisclosed and will no longer be protected.

I understand that I have a right to revoke this authorization by sending written notification to: **Digestive & Liver Disease Specialists, 885 Kempsville Rd., Suite 114, Norfolk, Va. 23502.** Any revocation will not affect disclosures made prior to **Digestive & Liver Disease Specialists'** receipt or knowledge of the revocation.

I understand that I have a right to inspect and receive a copy of the information described on this form.

I certify that I have received a copy of this authorization.

Signature_____ Date_____ Contact #_____

Picked up by patient or representative on _____

THERE MAY BE A SERVICE CHARGE FOR THE COPYING OF RECORDS