DIGESTIVE DISEASE CONSULTANTS, LTD.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if my health information is used or disclosed, the released information may no longer be protected by privacy regulations issued by the federal government. Medical Record #_____

Patient Name: _____ Date of Birth: _____Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Fax: _____

To disclose information from my medical records to:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Fax: _____

This information is needed for the following reason: _____
_____

What date are the records needed by: _____

The specific information I wish to have released is (**include dates of treatment**): _____
_____

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

_____ Date: _____
Signature (Legal Guardian/Parent if Minor Child)

_____ Expires: _____
Witness

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.

☐ I DO consent to have this information disclosed ☐ I DO NOT consent to have this information disclosed

_____ _____
Signature (Legal Guardian/Parent of Minor Child) Date

This medical record may contain information concerning HIV testing and/or AIDS diagnosis treatment. Separate consent must be given before this information can be released.

☐ I DO consent to have this information disclosed ☐ I DO NOT consent to have this information disclosed

_____ _____
Signature (Legal Guardian/Parent of Minor Child) Date

NOTE OF RECEIVING AGENCY/PARTY: Under the provisions of the Illinois Mental Health and Developmental disabilities Confidentiality Act, you may not disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. Under the Federal Act of July1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records maybe further disclosed without specific authorization for such disclosure.