Diagnostic Endoscopy LLC 778 Long Ridge Road Stamford, CT. 06992 Phone: 203-324-2400 Fax: 203-329-8855

Authorization to Release/Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____ Phone Number_____

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

This Information is to be disclosed to the following persons or organizations: Name:_____

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

The Purpose of the use or discloser is: ☐ At the Request of the Patient ☐ Other:_____

Method of Disclosure: ☐ Mail ☐ Pick Up (photo ID Required) Date_____ Time_____ (To be determined by office staff)

☐ Fax (Physician or Health Care Providers Only - all information is to be completed
Name of Physcian /Facility _____
Address_____ City_____ State_____ Zip Code_____

Release Content: Date(s) of service requested: From_____ To:_____

The Following Records: ☐ History & Physical; ☐ Discharge Summary; ☐ Lab Results;; ☐ Billing Records; ☐ Procedure Records; ☐ Progress Notes ☐ Photographs/ Images; ☐ Entire Medical Record; ☐ Summary of Treatment; ☐ Other (specify)_____

Revocation: I understand that I may revoke this authorization at any time by sending a written notice to the Center. However, the revocation will not have any effect on any uses or disclosures the center may have made before the revocation was received.

Expiration: I understand that unless I revoke the authorization earlier, this authorization will automatically expire six calendar months after the date the authorization is signed.

Re-disclosure: I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be re-disclosed by the receiving party.

Refusal to sign: I understand that I may refuse to sign this authorization and that the center will not condition treatment on whether I sign this authorization.

Certification: I certify that I am (check whichever applies) ☐ The patient, and the identification that I have provided is true and correct. ☐ The patient's authorized representative, and that the identification & proof of authority that I have provided are true and correct.

My relationship to the patient is that of _____.

Signature: _____ Signed this Date:_____

Print name: _____ Witness Signature:_____

Address: _____ Witness Print name: _____

Phone number: _____ Date: _____

(One Copy To Be Retained By The Requesting Party)

For Office Use Only:

Date received: _____ Expiration date: _____

How was the identity verified? _____ Copy made? ☐ Yes ☐ No

How was authority verified? _____ Copy made? ☐ Yes ☐ No

By: _____ Title:_____

Date: _____