



## Authorization to Release Medical Information

Capital Digestive Care is dedicated to maintaining the privacy of your protected health information. Federal and state laws ensure the privacy of your medical records, their availability to you, and specific rights regarding your medical records. In addition to your authorization, we may use or disclose your health information in accordance with the law under certain circumstances. Please refer to our full HIPAA Notice of Privacy Practices for all potential general use and disclosures.

### I UNDERSTAND MY RIGHTS TO:

Revoke or change the authorization below at any time. (Please note, revocation is not effective in cases where the information has already been disclosed but will be effective going forward from the notice to revoke). I may also inspect or copy my protected health information to be disclosed as described in this document. I understand that if the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

### **DISCLOSURE AND RELEASE OF PAPER OR ELECTRONIC RECORDS:** (Choose and initial only **one** option)

\_\_\_\_\_ I **DO NOT** authorize the disclosure or release of my protected health information to any person/entity or via a  
*Initial* message left on a voicemail beyond the authorized uses and disclosures as described in the Notice of Privacy Practices.

\_\_\_\_\_ I authorize the physicians and staff of the practice to disclose health information regarding appointments, labs  
*Initial* bills or other general patient communication via voicemail on the following telephone numbers:

Telephone #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

\_\_\_\_\_ I authorize the disclosure or release of the following protected health information:  
*Initial*

- All records
- Office visit notes
- Pathology Reports
- Radiology Reports
- Laboratory Reports
- Other (specify): \_\_\_\_\_

This information may be disclosed or released to: Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_

This authorization expires on: \_\_\_\_/\_\_\_\_/\_\_\_\_ (if no date specified, an automatic expiration occurs in one year).

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name/Title of Representative