AKRON DIGESTIVE DISEASE CONSULTANTS, INC.

570 WHITE POND DR, SUITE 100, AKRON OH 44320

P 330 869 0124 F 330 869 2852

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION FROM COVERED ENTITIES

Fields with * are required. Failure to provide additional identifying info in Section I may result in the inability to respond to this request. This form isn't a patient access request under 45 CFR 164.524. *Records released pursuant to this authorization may include information concerning testing, diagnosis, or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual abuse.*

SECTION I				
FIRST NAME*	**M.I.**	**LAST NAME***	**DOB***	**SSN**
ADDRESS		**CITY**	**STATE**	**ZIP CODE**

I hereby authorize the disclosure of health information about the above individual as follows:

SECTION II

RECORDS TO BE RELEASED FROM AKRON DIGESTIVE DISEASE CONSULTANTS, INC. (FAX IS PERMITTED) ☐

ENTITY TO RELEASE TO _____

ADDRESS	**CITY**	**STATE**	**ZIP CODE**
PHONE	**FAX**		

RECORDS REQUESTED FROM BELOW ENTITY TO BE RELEASED TO AKRON DIGESTIVE DISEASE CONSULTANTS, INC. (FAX IS PERMITTED). ☐

ENTITY NAME REQUESTED FROM: _____

ADDRESS	**CITY**	**STATE**	**ZIP CODE**
PHONE		**FAX**	

SECTION III

REASON FOR DISCLOSURE*

HEALTH INFORMATION TO BE DISCLOSED:

CHECK HERE IF ENTIRE RECORD □

SPECITY TIME PERIOD, IF DESIRED:
RELEASE ONLY INFORMATION FROM THE PERIOD _____(mm/dd/yyyy) to _____(mm/dd/yyyy)

SECTION IV

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED OR SHALL EXPIRE ON DATE OR EVENT SPECIFIED BELOW. I UNDERSTAND THAT I MAY REVOKE OR CANCEL THIS AUTHORIZATION AT ANY TIME BY SUBMITTING A WRITTEN REVOCATION IN THE MANNER SPECIFED BY THE DISCLOSING ENTITY, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION. IF THIS AUTHORIZATION HASN'T BEEN REVOKED, IT WILL EXPIRE ON THE DATE OR COMPLETION OF THE EVENT STATED BELOW. IF NO DATE OR EVENT IS SPECIFIED BELOW, THIS AUTHORIZATION WILL EXPIRE IN ONE YEAR.

EXPIRATION DATE OR EVENT_____(mm/dd/yyyy)

*I UNDERSTAND THAT I MAY NOT BE DENIED TREATMENT, PAYMENT, AND ENROLLMENT IN THE HEALTH PLAN, OR ELIGIBILITY FOR BENEFITS FOR REFUSING TO AUTHORIZE DISCLOSURE UNLESS SUCH DENIAL IS PERMITTED UNDER STATE AND FEDERAL LAW.
*I UNDERSTAND THAT INFORMATION DISCLOSED BY THIS AUTHORIZATION, EXCEPT AS PROHIBITED BY 42 CFR PART 2 OR OTHER APPLICABLE LAW, MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NOT LONGER BE PROTECTED BY THE HIPAA PRIVACY RULE {45 CFR PART 164}

SIGNATURE OF INDIVIDUAL*	**DATE*(mm/dd/yyyy)**
SIGNATURE OF REPRESENTATIVE (IF APPLICABLE) *IDENTIFY RELATIONSHIP TO INDIVIDUAL BELOW)	**DATE*(mm/dd/yyyy)**

RELATIONSHIP OF REPRESENTATIVE TO INDIVIDUAL (PERSONAL REPRESENTATIVE SHALL SUBMIT PROOF OF AUTHORITY)

☐ PARENT ☐ LEGAL GUARDIAN ☐ HEALTHCARE POA ☐ EXECUTOR/ADMINISTRATOR ☐ OTHER ☐ N/A

FOR OFFICE USE ONLY: METHOD OF DELIVERY: _____DATE RELEASED: _____