AKRON DIGESTIVE DISEASE CONSULTANTS, INC.

RELEASE OF PRIVATE HEALTH INFORMATION AUTHORIZATION

Patient Name:____

Date of Birth: ________________________

Social Security Number: _______________________________________

Please list any individuals you would like us to be able to share your information with; other than your referring physician. (For example: a family member)

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Please initial next to the information you would like us to share:

Medical Health information (including STD, HIV, Hepatitis) information ___________

Medical Health information (EXCEPT STD, HIV, Hepatitis) information ___________

Financial/Billing information _________

This authorization will be valid until : (Initial choice)

As long as I am a patient here__________
(initial)

Other _____________ ___________
(date) (initial)

Signature:________________________________ **Date:**___________________

Witness: _________________________________ **Date:** ___________________