

DIGESTIVE & LIVER DISEASE SPECIALISTS
A member of Gastrointestinal & Liver Specialists of Tidewater, PLLC
885 Kempsville Rd. Suite 114
Norfolk, Va. 23502
Phone 757-466-0165 Fax 757-466-7296

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS OR MEDICAL INFORMATION

TO: _____

PATIENT'S NAME: _____ ACCT. #: _____

SS #: _____ DOB: _____

REQUESTED BY: _____ _____ _____	PROVIDE RECORDS/INFORMATION TO: _____ _____ _____ Att: _____
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Specific description of information (including dates): _____

The information described above will be used or disclosed for the following purpose(s): _____

Expiration date: _____

To be completed by the patient or personal representative

I hereby authorize the use or disclosure of my protected health information as described above.

I understand that this authorization is voluntary. I understand that ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness-for-duty evaluation or a research-related treatment.

I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be redisclosed and will no longer be protected.

I understand that I have a right to revoke this authorization by sending written notification to: **Digestive & Liver Disease Specialists, 885 Kempsville Rd., Suite 114, Norfolk, Va. 23502.** Any revocation will not affect disclosures made prior to **Digestive & Liver Disease Specialists'** receipt or knowledge of the revocation.

I understand that I have a right to inspect and receive a copy of the information described on this form.

I certify that I have received a copy of this authorization.

Signature of patient or patient's representative

Signature

Date