Atlantic Digestive SPECIALISTS
Helping people inside & out

Request for Release of Medical Records

Protected Health Information Release Authorization

Patient Name: _____**Date of Birth:** ____/____/_____ **Today's Date:** _____

Atlantic Digestive Specialists is authorized by me to use, disclose, release or request my protected health information as directed by me for a purpose of treatment, payment, or health care operations. I have read this authorization and indicated on this form explicitly which information will be used, disclosed, released, or requested and the recipient(s) of that information. I specifically authorize any current employee or owner of Atlantic Digestive Specialists, to disclose my protected health information as described on this form to the recipients listed below. I understand that by providing permission to authorize disclosure of my protected health information, the recipient may further disclose this information and Federal law may no longer protect it. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

➢ **Please check the applicable statement below and provide the following:**

Full Name of Person/Facility - Complete Address - Telephone Number with Area Code

□ **Send my healthcare record information to:** _____

_____

_____

□ **Request my healthcare record information from:** _____

_____

_____

Please Note: Record requests may take 30 days to process.
□ Urgent Request: Please *rush* this request and process on or before: _____

➢ Using check boxes, provide a description of the information to be released or requested (check all that apply):
[ ] Entire medical record
[ ] **and/or** Medical Data/Information as only related to:
[ ] Lab(s) and/or X-ray(s) [ ] Office Visit(s) [ ] Office and/or Hospital Procedure Note(s)
[ ] Confidential Information: (i.e.; HIV, Alcohol, Drug Information, Mental Health) [ ] Other_____
[ ] **No longer require Atlantic Digestive Specialists services.**

➢ This authorization shall expire on ___ /_____/ ____ or 12 months from the date below. After this date, Atlantic Digestive Specialists can no longer use or disclose the patient's protected health information without first obtaining a new authorization form. **I fully understand and accept the terms of this authorization.**

_____ _____ _____
Patient/Guardian/POA Signature **Date** **Relationship to Patient (if applicable)**

For releases requesting healthcare information to be released from Atlantic Digestive Specialists only:
The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective Atlantic Digestive Specialists must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization
- The recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

Atlantic Digestive Specialists accepts written revocations of this authorization via:
[ ] Certified U.S. mail or [ ] Facsimile at this number: **(603) 692-4748**

ALL revocations must be sent to Atlantic Digestive Specialists to the attention of the Privacy Officer and/or the Deputy Privacy Officer and are not effective until received by the Privacy Officer and/or Deputy Privacy Officer.