DIGESTIVE DISEASE AND NUTRITION CENTER OF WESTCHESTER, LLP.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please Print Information
Patient: ______________________ Birth date: __________ SSN: __________________

Former Name: ______________________ Home Ph: ______________________

Cell No. ______________________ Email: ______________________

Address: Street ______________________ Apt# ________ City, State, Zip______________________

I hereby authorize the release my medical information by/to following by/to DDNCW:

Name: ____

Street: ______________________ City: __________________ State: ________ Zip: ________

1. Information Requested:
   - Lab and/or x-ray reports, *Date*___________
   - Operative reports, *Date*________
   - Records related to, *Date*________
   - Financial Records, *Date*________

2. Purpose of disclosure:
   ____ Continued Patient Care ____ Personal Use ____ transferring to new physician
   ____ other, specify ______________________________________

3. Medical information includes: information about communicable diseases, TB, STD, HIV, HIV testing, AIDS and ARC. It also includes information regarding alcohol, drug, and mental health related treatment.

4. I do not authorize release of (please specify): ______________________

It is further understood that the information released is for specific purpose stated above and may no be provided in whole or in part to any other agency, organization, or person. I further understand that correspondence, patient discharge instructions and records from other health care providers will not be release with this consent.

I also understand that this authorization may be revoked by me (the patient or legal representative) at any time, except after the release described above has taken place.

____

Patient's (or Legal Representative's) Signature Date

____

Witness' Signature Relation to Patient Date