AUTHORIZATION TO RELEASE MEDICAL INFORMATION

DIGESTIVE DISORDERS ASSOCIATES
FEES FOR
COPYING PATIENT RECORDS

Total Cost Includes:

- Preparation fee $22.00
- $0.73 per page

Please allow 5 to 10 business days for records to be copied.

Any missing or inaccurate information on the authorization to release records may delay or void the request.

Once the records are copied an invoice will sent to the requesting party along the records.

We **do <u>not</u> fax** complete medical records.

We highly recommend patient's request records be mailed directly to them to ensure proper receipt.

Our records are currently being copied offsite by Sandia Medical Records.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name _____ Birth date (Mo/Day/Yr) _____

Street Address _____ Social Security Number _____

City, State, Zip code _____ Phone _____

I authorize Digestive Disorders Associates to release my medical records as specified below:

____All Medical Records ____Office visit notes ____Bravo/Capsule Endoscopy/Remicade
____Laboratory Reports ____ Radiology Reports ____Colonoscopy/EGD/EUS/ERCP Report
____Pathology Reports ____Other (specify)_____

Service Date(s):For the last:_____ 5 years _____2 years ____6 Months ____Other_____year(s)/month(s)
OR From _____ to _____

___I do ___I do NOT authorize release of information related to AIDS(Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

REASON FOR REQUEST
___Referral to Specialist ___Insurance ____Workers Comp ___Legal Investigation
___Disability Determination ___Personal ____Out of State Move ___Change GI Dr
___Other (specify)_____

Name of Individual or Organization: _____
Street Address: _____
City, State, Zip Code: _____

DELIVERY METHOD: (please ✓one)
__Mail to patient

__Mail to organization/individual address listed above

I understand I have the right to revoke this authorization at any time and that I must do so in writing and present my written authorization to Digestive Disorders Associates. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand my revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise specified, this authorization will automatically expire in one year.

I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand any disclosure of my information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Privacy Officer for Digestive Disorders Associates at 410-224-4887.

_____ _____
Signature of patient, guardian or Personal Representative of patient's estate — Date

NOTE:Per Maryland law, Health-General Article Section 4-304(c)(3) as of 2004 physicians are allowed to charge specific sums for and production of medical records that is adjusted annually for inflation. Please refer to MedChi.org for current fee amounts.