Allied Digestive Health
FAX: 732-548-7408

Advanced Gastroenterology Associates
Allied Digestive Health Pathology
Atlantic Coast Gastroenterology Associates
Monmouth Gastroenterology
Red Bank Gastroenterology Associates
Shore Gastroenterology Associates

RECORDS RELEASE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

1. I am requesting protected health information/ medical records be released for the following person:

- **Patient Name:** _____ **Birthdate**: ___/___/_____
- **Phone Number**:____-_____-_____ **Maiden or other name:** _____
- **Physician's Name(s) Who Treated the Patient was:** _____
- **Date Records Needed:** _____

2. I am authorizing the following medical information (check all that apply) be released/ disclosed:

☐ **All** ☐ **Operative Reports** ☐ **Pathology Reports** ☐ **Lab Results** ☐ **Radiology Reports** ☐ **Hospital Records**

Other:_____

Please indicate date(s) of treatment:_____

3. Please forward the requested medical information, for the identified Patient, by the desired date, to:

- **Name** _____
- **Adddress:** _____
  _____

4. Signature Authorization:

- I understand that I have the right to revoke this authorization at any time.
- I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure.
- I understand that the revocation does not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked this authorization will expire in two months or on this date listed _____. I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law.
- I understand that I need not sign this authorization to assure treatment.
- I understand that I may inspect and/or copy the information to be disclosed.
- I understand that authorizing is voluntary. I understand that if I have any questions about disclosure of my health information,
- I may contact Allied Digestive Health privacy officer that is authorized to disclose this information and request a copy of this authorization.
- I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information or genetics. THIS INFORMATION WILL ALSO BE RELEASED UNLESS YOU INDICATE; ____ DO NOT RELEASE (Indicate with a check mark).

I understand, and, consent and agree to these statements:

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Representatives Authority to Act on Behalf of Patient Signature of Witness