Dayton
Gastroenterology, Inc.

**Patient Name:**_____

**Date of Birth:** _____ **Account Number:**_____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses.

| **Organization providing the information:** | **Organization receiving the information** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Reason for disclosure:** _____

**Specific description of the information (including date(s) of healthcare) to be disclosed:**

| | |
|---|---|
| ____ Most recent 2 years of records | ____ All upper and lower Endoscopy procedures and associated pathology reports |
| ____ Progress Notes | ____ Inpatient Records |
| ____ Consultations | ____ Operative Reports |
| ____ Outpatient Records | ____ Pathology Reports |
| ____ X-ray Reports | ____ Copies of entire Record |
| ____ Lab Reports | ____ Other (please specify) |

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. **This authorization will expire ninety days from the date of authorization written below.** I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment.

I understand that once my health care information is released, the released information may no longer be protected by federal privacy regulations.

_____ _____

**Signature of patient or patient's representative** **Date**

*(This form MUST be completed before signing)*

**Printed name of patient's representative: _____**

**Relationship to the patient: _____**