

DIGESTIVE HEALTH CLINIC, LLC
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of patient: _____ DOB: _____

I hereby authorize the use or disclosure of protected health information as described below:

1. The Digestive Health Clinic and its affiliated physicians or employees may disclose the information to:

OR the Digestive Health Clinic and its affiliated physicians or employees may receive and use information from:

2. Specific information to be used or disclosed:

- Psychotherapy notes (cannot be combined with another authorization)
- Medical records (describe, including inclusive dates): _____
- Oral communications
- Other (describe): _____

3. Purpose for use or disclosure (*check one*):

- The use or disclosure is at the request of the individual.
- The use or disclosure is for marketing purposes. The health care provider will / will not (*circle one*) receive remuneration from a third party for the use or disclosure of information.
- Other (describe the purpose): _____

4. This authorization will expire on the following date or event:

- One year from the date of the authorization.
- Other (specify): _____

I understand that the Digestive Health Clinic or other health care provider may not condition my treatment on provision of this authorization unless the authorization is for the use or disclosure of information for research-related treatment, or unless the treatment is solely for the purpose of disclosing information to a third party (e.g., an employment physical).

I understand that I may revoke this authorization at anytime unless the Digestive Health Clinic or other health care provider has taken action in reliance on the authorization. To revoke the authorization, I must submit a written request to:

Digestive Health Clinic
Attn: Health Information Manager
6259 Emerald Street
Boise, Idaho 83704
fax: (208) 375-5286

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by applicable law.

Signed by: _____ Date: _____

(If signed by personal representative, describe authority)

Note: If this authorization is requested by the Digestive Health Clinic, give a copy of this authorization to the patient or their personal representative.