Digestive Care Specialists

1026 E. 2nd St.
Casper, WY 82601
Phone: 307-333-0002
Fax: 307-333-4425

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Printed Name of Patient (first, middle, last name)	Date of Birth (MM/DD/YYYY)
Address (Street Address, City, State, Zip Code)	
Phone Number:	E-mail

Person/Organization to **Release** Information	Address (Street Address, City, State, Zip Code)
Phone Number:	Fax Number

Person/Organization to **Receive** Information	Address (Street Address, City, State, Zip Code)
Digestive Care Specialists	**1026 E. 2nd St Casper, WY 82601**
Phone Number: **307-333-0002**	Fax Number **307-202-5112**

The above person/organization is hereby authorized to receive the following health information that relates to service beginning from_____to _____, may be released. (Please check all that apply below)

____Entire Medical Record ____Patient Histories ____Office Notes/Consults ____Procedure Notes
____Radiology ____Labs Results ____Billing Records ____Insurance Records

I am aware that information in my health record may include information relating to Sexually Transmitted Disease, Accuired Immunodeficiency Syndrome (AIDS), Human Immunideficiency Virus (HIV) and other communicable diseases, Behavioral Health/Psychiatric care, and treatment of alchohol and/or drug abuse.

If Digestive Care Specialists is being authorized to release health information to another party, I understand and agree that this information may be subject to re-disclosure by the recipeint and may no longer be protected by law.

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I understand that I can revoke this authorization at any time by writing to Digestive Care Specialists. However, revoking this authorization will not affect disclosures made or actions taken before revocation is recieved.

I have read (or have had read to me) this authorization, and I agree to its terms as indiated by signing below. I am entitled to a copy of this authorization.

Signature of Patient/Repesentative Signature_____ Date____/____/____