CENTER FOR DIGESTIVE DISEASES
AND CARY ENDOSCOPY CENTER, PC
1120 SE CARY PARKWAY STE. 204
CARY, NC 27518
PHONE (919) 854-0041
FAX (919) 854-0049

(Print patient's full name) _____ Birthdate (mo/day/yr) _____

(Street Address) _____ (Social Security Number) _____

(City, State, Zip Code) _____ Phone (home) _____

At the request of the individual, I _____ do hereby authorize:

Center for Digestive Diseases
1120 SE Cary Parkway, Ste. 204
Cary, NC 27518
(919) 854-0041(phone) (919) 854-0049 (fax)

To release the following: (Please check all that apply)

____ All Records	___Pathology Reports	____Emergency Reports
____History & Physical	___Laboratory Reports	____ Discharge Summary
____Progress Notes	___Radiology Reports	Other_____
____Operative Notes	___ECG/EEG/Cardio Cath	

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

Information released to: _____
(name of facility or provider)

_____
(street address, city, state, zip)

_____
(fax number)

Purpose of Disclosure:

____Referral to specialist _____Insurance _____Workers Compensation _____Change of Doctor

____Legal Investigation _____Disability Determination _____Continuing Care

____ Permanent Transfer to another GI ____Other_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized or furnished may not condition its treatment of me on whether or not I sign the authorization.

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

The maximum fee for each request shall be 75 cents per page for the first 25 pages, 50 cents per pages for pages 26-100 , and 25 cents for each page in excess of 100 pages, provided that the health care provider may impose a minimum fee of up to $10.00, inclusive of copying costs.