Digestive Disease Specialists

525 Valley View Drive | Moline, IL 61265 | Phone: 309-601-2800 |Fax: 309-601-2801
3400 Dexter Court | Pavilion 1 | Suite 108 | Davenport, IA 52807 | Phone: 563-345-2438 | Fax: 563-345-2528

Ahmad Cheema, M.D. Poonputt Chotiprasidhi, M.D. Linda Tong, M.D., AGAF
Shannon Johnson, PAC Chelsea Mausser, APRN Tammy Torsch, APRN

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ DOB:_____/_____/_____

Previous Name(s):_____

I authorize Digestive Disease Specialists, P.C. To request my health care information/previous medical records from:

Physician/Practice:_____ Phone/Fax:_____

Address:_____

I authorize Digestive Disease Specialists, P.C. to release my records and any information checked below to the following individual(s):

Name:_____ Phone:_____

Relationship to Patient:_____

- ☐ All Information
- ☐ Blood Work
- ☐ Medication Information/Refills
- ☐ HIV Results
- ☐ Procedures and Results
- ☐ Appointment Information

I release Digestive Disease Specialists, P.C. from any liability resulting from the release of this confidential information. I have the right to revoke this authorization at any time. I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected federal or state law and may be subject to disclosure by the above recipient. You have the right to revoke this consent in writing, send written notice to the above address. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the manager at the above address.

This agreement will expire two years from the date of signature or as indicated (specify number of days or months) _____ unless cancelled by the patient/guardian.

_____ _____
Signature of patient or legally authorized individual Date signed

_____ _____
Printed name of authorized individual if signed on behalf of patient Relationship to patient