



Digestive Specialists, Inc.

www.digestivespecialists.com

Phone: (937) 534-7330

Fax: (937) 297-2203

Authorization for Release of Medical Information

I hereby grant my permission for release of and/or copying of medical information between the following parties, with no limitations, including any information concerning treatment, i.e., medical/surgical, psych, alcohol and drug related, or HIV/AIDS.

From:

To:

I direct that all information obtained in association with this release be held in a strict confidence by the recipient and further direct that it is not further disclosed without my specific written authorization. I understand this consent shall remain in effect for 60 days for med/surg/psych/HIV patients from the date of my signature below, unless I specify an earlier date in this space _____. I understand, also, that except to the extent that action has been taken on my authorization, I may withdraw this authorization at any time by written notification to the parties involved.

Information/Reports Requested - Check Specific Areas

- | | | |
|---|---|--|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> HIV/ARC/AIDS | <input type="checkbox"/> Therapy Notes |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Drug/Alcohol Related | <input type="checkbox"/> Emergency Treatment |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Other – please specify: _____ |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Physician Progress Notes | |

To assist you, I am providing the following identifying data:

Patient Name (at time of treatment)

Date of Birth

Social Security Number

Treatment Dates (specify inpatient, clinic, emergency, outpatient, etc.)

Purpose for Disclosure

Signature of Patient or Guardian

Date

Witness

Location:

- | | |
|---|---|
| <input type="checkbox"/> 4340 Clys Road • Sugarcreek Twp., OH 45459 | <input type="checkbox"/> 77 W. Eleanor Drive • Springboro, OH 45066 |
| <input type="checkbox"/> 1530 Needmore Road, Suite 101 • Dayton, OH 45414 | <input type="checkbox"/> 5697 Shull Road • Huber Heights, OH 45424 |

Physician:

- | | | |
|--|--|---|
| <input type="checkbox"/> David M. Novick, M.D., FACP | <input type="checkbox"/> Malay Dey, M.D., Ph.D. | <input type="checkbox"/> Kanan Sharma, M.D. |
| <input type="checkbox"/> Marios C. Pouagare, M.D., Ph.D. | <input type="checkbox"/> Christopher Barde, M.D. | <input type="checkbox"/> Mustafa Musleh, M.D. |
| <input type="checkbox"/> Teresa Patrick, M.D. | <input type="checkbox"/> Jigna Thakore, M.D. | <input type="checkbox"/> Tristan Handler, M.D. |
| <input type="checkbox"/> Narayan Peddanna, M.D. | <input type="checkbox"/> Salma Akram, M.D. | <input type="checkbox"/> Jonathan Kushner, M.D. |
| <input type="checkbox"/> Rajkamal Jit, M.D. | <input type="checkbox"/> Nagaraja Oruganti, M.D. | |
| <input type="checkbox"/> Bikram Verma, M.D. | <input type="checkbox"/> Urmeem Siraj, M.D. | |