TDDC
Texas Digestive Disease Consultants

Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information, then sign and date form.

Patient Name:	Social Security Number:	DOB:

Who is Authorized to Receive Information:

I authorize Texas Digestive Disease Consultants to disclose or provide protected health information about me to the following person(s) or entity:

Name:	Telephone Number(s):	Relationship:
Name:	Telephone Number(s):	Relationship:
Name:	Telephone Number(s):	Relationship:

Information to Be Disclosed:

I authorize Texas Digestive Disease Consultants to disclose or provide the following types of protected health information to the person(s) or entity identified above:

☐ All Information about specialist care received ☐ All Diagnostic Test Results ☐ Lab Results Only

☐ Billing Statement of Charges for Care Only ☐ Other (specify): _____

Purpose of Disclosure:

The disclosure / use of the types of protected health information noted above is for the following purposes:

☐ At my request ☐ To discuss with my family the care and treatment I receive ☐ Payment by 3rd party, other than health insurance

☐ Other (specify): _____

Expiration of this Authorization: This authorization will expire 1 year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue authorization. You have the right to terminate this authorization at any time by notifying the TDDC Privacy Manager in writing. Please specify expiration date if less than 1 year: _____

Redisclosure: TDDC has no control over the person(s) or entity you have listed to receive your protected health information. Therefore, protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

_____ _____
Patient Signature Date

_____ _____
Patient Signature Date

_____ _____
Patient Signature Date