**DIGESTIVE HEALTH CENTER**
GASTROENTEROLOGY OF INDIANAPOLIS
Daniel J. Stout, M.D.
1120 AAA Way
Carmel, IN 46032
Office: (317) 848-5494
Fax: (317) 575-0392


# Authorization for the Release of Medical Information

Records to be released from: **Digestive Health Center**
Dr. Daniel J. Stout
1120 AAA Way
Carmel, IN 46032
Office: 317-848-5494
Fax: 317-575-0392

This will authorize DHC to release the medical records of:

Patient's Name:______________________________ Date of Birth: _______________

Phone Number(s): (_____)___________________ (home)
(_____)___________________ (work)
(_____)___________________ (cell)

Released to:

Name:______________________________ Phone Number: __________________

Method of Release: ☐ Fax* ☐ Mail ☐ Pick up from DHC

If Faxed, Fax Number: (_____)___________________ *note: is request is more than 10 pages, it may need to be mailed

If Mailed, Address: ______________________________
______________________________
______________________________

Date(s) of Medical Records to be Released: ______________________________

Information to be Released:

☐ Colonoscopy Report(s) ☐ Upper Endoscopy Report(s) ☐ Lab(s)

☐ Consultation Note(s) ☐ Biopsy(ies) ☐ All

☐ Other (please specify) ______________________________

By signing below, I understand that my "protected health information" that is used or disclosed under this authorization may be subject to redisclosure by the recipient, and therefore may no longer be protected by law. Furthermore, I understand that I may revoke this authorization at any time, except to the extent that action has already been taken. Otherwise, this authorization will be considered valid for thirty (30) days.

By signing below, I acknowledge that I have read and understand this authorization. I authorize the use or disclosure of my "protected health information" in accordance with the terms of this authorization.

Patient/Authorized Representative Printed Name: _________________________
Patient/Authorized Representative Signature: _________________________ Date: __________
Witness Printed Name: _________________________
Witness Signature:_________________________ Date: __________