Digestive Disease Associates of Rockland, PC
974 Rte 45
Pomona, NY 10970
*845-354-3700 * fax 845-354-5439*

AUTHORIZATION FOR RELEASE OF INFORMATION FROM DDAR

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

PATIENT NAME:_____

Date of Birth:_____

Name and address of Organization PROVIDING the information:

Dr. ☐**Elliot Heller** ☐**Richard Moccia** ☐**Andrew Goldenberg** ☐**Alfred Hollander**
☐ **Vipul Shah** ☐ **Viyada Sarabanchong**
DIGESTIVE DISEASE ASSOCIATES OF ROCKLAND, PC
974 RTE 45
POMONA, NY 10970

Name and address of Organization RECEIVING information

_____

_____

_____

_____

Specific description of the information (including date (s) of health care) to be disclosed:

_____

_____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ____/_____/____, 2_____. _____
Initials
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any action taken by the providing organization before they received the revocation. _____
Initials

_____ _____
Signature of Patient or Patient's representative **Date**

_____ _____
Printed Name of Patient or Patient's Representative **Relationship**