



Digestive Disease Associates Of Rockland, PC

974 Rte 45 • Pomona, NY 10970
845-354-3700 • 845-354-5439 (fax)

Dear Patient:

As you are aware, there are very strict governmental mandated rules concerning patient confidentiality and release of a patient’s medical information. Therefore, in our continuing efforts to improve patient/physician communications, DDAR can offer you additional ways to receive information, with your signed authorization, concerning your care and treatment.

PART I:

If there is any FAMILY MEMBER OR FRIEND whom we may discuss or release information on your behalf, please list them here: **No one**

Name	Relationship

I understand that I may revoke or change this authorization at any time in writing.

Signature

Date

Print Name

PART II:

If you would like to authorize us to receive information/results from any other physician, health care provider, radiology group or laboratory, please check or list them here:

None

Please use blank lines for “other”

- | | | |
|---|---|---|
| <input type="checkbox"/> MRI (Any Site) | <input type="checkbox"/> Quest Laboratories | <input type="checkbox"/> Good Samaritan Hospt |
| <input type="checkbox"/> Ramapo Radiology | <input type="checkbox"/> Rockland MediLabs | <input type="checkbox"/> Nyack Hospital |
| <input type="checkbox"/> Dr. Weg | <input type="checkbox"/> LabCorp | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Ramapo Diagnostics | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

I understand that I may revoke or change this authorization at any time in writing.

Signature

Date

Print Name
