DHAT

Our office is pleased to have the opportunity to serve you. Our primary mission is to provide you with quality, cost-effective medical care. Together, we (patients and your healthcare team) are trying to adapt to the changing ways that healthcare is financed and delivered. The following guidelines were developed to help you through the process.

Payment Guidelines:

- We collect co-payments, co-insurance, and/or deductibles at the time of service unless other written arrangements have been made in advance with our office.
- We accept **Cash, Checks, Money Orders, and Credit Cards** (Visa, Mastercard, American Express and Discover).
- If your check is returned, a processing fee of $30 will be assessed in addition to the amount of the check.
- A claim will be sent to your insurance company for payment. If your insurance company remits the payment to you, please send the payment to our office, along with the Explanation of Benefits.
- Any balance that your insurance company determines to be your financial responsibility will be billed to you. Payment is due in full upon receipt of your statement. Balances that remain unpaid after 90 days may be referred to an outside collection agency for further collection efforts. _____ (initial)

No Show / Late Cancellations:

To provide the best possible service and availability to all patients, our practice has implemented the following fees:

- **Office visit** – We require a 1 business day notice for all office visit cancellations. If the required notice is not given, a $50.00 charge may be assessed to the patient account.
- **Procedure** – We require a 3 business day notice for all procedure cancellations. If the required notice is not given, a $100.00 charge may be assessed to the patient account.

The missed appointment payment may be required prior to, or upon the next scheduled procedure or office visit.

Ancillary Services:

Your physician may refer you to one or more "ancillary services" in connection with your medical care. An ancillary service is a service supplementing or supporting your medical treatment. The following are considered, but not limited to, possible ancillary services:

- Ambulatory Surgery Center
- Infusion Therapy
- Laboratory & Pathology Testing
- Nutritional Services
- Pharmacy Services
- Radiology/Imaging

Your physician may have an economic interest in or business relationship with the company or person who provides the ancillary service(s). You are not obligated to use the provider that your physician refers you to. You are free to use any provider you choose.

Research Programs:

Your physician may ask if you would like to participate in a clinical trial or research program. These programs may be sponsored by a drug company or may be a practice-sponsored research program. Your physician may be compensated for services rendered in connection with these programs. You are not obligated to participate in any research program and your permission will be obtained prior to your participation in a program that your physician believes may be appropriate for you.

When to present your insurance card:

Please present your insurance card at **EACH VISIT.** Specifically bring to our attention any changes (new card, new subscriber or group number, etc.) since your last visit. This protects you from paying a bill due to providing incorrect information. There is a narrow window (30-45 days) to present an accurate claim to the correct insurance company. Failure to do so could mean the claim may be denied. If you have a secondary insurance, it will be filed as a courtesy. However, if we have not received payment from your secondary insurance in a timely manner, the balance will become your responsibility.

Assignment of Benefits:

DHAT may file a claim for services rendered by the physician, facility, pathologist and or anesthesia provider. DHAT is authorized to transfer any patient overpayment to one of these associated entities if applicable. I hereby authorize DHAT to:

- Release any information necessary to the insurance company regarding my illness and treatments.
- Process claims generated for my examination/treatment.
- Allow a photocopy of my signature to be used to process insurance claims for a period of a lifetime.
- Keep this order in effect until it is revoked by me in writing.

We value you as a patient and we are eager to serve you! Our priority is to provide you with the best possible care. If you would like to contact our Central Business Office, you may do so at 214-689-3829 or 1-800-425-3759.

I have read and understand the guidelines and financial obligations as stated above.

_____ _____

Signature Date

DHAT

Digestive Health Associates
of Texas, P.A.

SINDHU A. ABRAHAM, M.D.

PATIENT INFORMATION

Date: ____-____-____ Who referred you to us? _____

PCP/Internist: _____ Patient's Email Address: _____

Name: _____ Birth date: ____-____-____ Age _____ Sex: M / F

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone # ( ) _____ Work Phone # ( ) _____ Cell Phone # _____

Social Security # ____-____-____ Marital Status: (circle one) Single Married Divorced Widowed

Employer: _____ Address: _____

Patient's Occupation: _____

Language Spoken: _____ Patient's Race: _____

Name of Spouse: _____ Spouse SS#: ____-____-____ Birth date: ____-____-____

Spouse Employer: _____ Address: _____

Spouse's Occupation: _____

Spouse Work Phone # _____ Spouse Cell Phone # _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Reason for Office Visit: _____

_____

Primary Insurance: _____

Insured's Name: _____

Claim Form Address: _____ City: _____ State: _____ ZIP: _____

Insured's ID #: _____ Group #: _____ Phone #: _____

Secondary Insurance: _____

Insured's Name: _____ Birth date: ____-____-____

Address: _____ City: _____ State: _____ ZIP: _____

Insured's ID #: _____ Group #: _____ Phone #: _____

Pharmacy Name / Address: _____ Phone #: _____

I understand that if any of the insurance information I have provided is incorrect or if I fail to notify the office of any insurance changes, that I am responsible for all physician charges and non-covered medical services.

I hereby authorize the release of any medical information necessary for the process of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to DIGESTIVE HEALTH ASSOCIATES OF TEXAS, P.A. and DIGESTIVE HEALTH MANAGEMENT ENDOSCOPY CENTERS. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I have received the Notice of Privacy Practices.

Patient's Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW DIGESTIVE HEALTH ASSOCIATES OF TEXAS, P.A. MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protected health information, about you, is obtained as a record of your contacts or visits for healthcare services with DIGESTIVE HEALTH ASSOCIATES OF TEXAS, P.A. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

DIGESTIVE HEALTH ASSOCIATES OF TEXAS, P.A. is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose you protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

If you have any questions about this Notice please contact our Privacy Manager at 214-689-5960

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure - This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative - This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protect health information.

You have the right to inspect and copy your protected health information - This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. In certain cases we may deny your request.

You have the right to request a restriction of your protected health information - This means you may ask us in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.

You have the right to have us amend your protected health information - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have to right to request a disclosure accountability - This means that you may request a listing of your protected health information disclosures we have made to entities or persons outside of our office.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment - We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment.

We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. And, we may contact you to provide information about health related benefits and services offered by our office.

For Payment - Your protected health information will be used, as needed, to obtain payment of your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations - We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes Education, provider credentialing, certification, underwriting, rating or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating deidentified information.

Other Permitted and Required Uses and Disclosures

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To Others Involved In Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected healthcare information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required By Law - We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

For Public Health - We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

For Communicable Diseases - We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

For Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

To The Food and Drug Administration - We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

For Legal Proceedings - We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

To Law Enforcement - We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

To Coroners, Funeral Directors, and Organ Donation - We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

In Cases of Criminal Activity - Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

For Military Activity and National Security - When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services.

For Workers' Compensation - Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

When an Inmate - We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures - Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

DIGESTIVE HEALTH ASSOCIATES OF TEXAS, PA

PATIENT'S HISTORY

Name: _____ Date: _____

Date of Birth: _____ Age: _____ SSN: _____

Reason for Visit: _____ Referring Physician: _____

PAST MEDICAL AND SURGICAL HISTORY

Date Hospital/Location Doctor Reason for Hospitalization

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have you had the following **surgeries**? (Please circle): appendectomy, tonsillectomy, hysterectomy, hernia surgery, cosmetic surgeries, gallbladder surgery, heart bypass, angioplasty.

Please list all of your other current doctors: _____

For Females: Last menstrual cycle: _____; # Pregnancies ____ # Deliveries ____ # Miscarriages ____

Conditions Check (x) conditions that you have had or are having

- ❑ AIDS/HIV Positive
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Depression
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy/Seizures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia: Inguinal/Hiatal
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Migraine Headaches
- ❑ Mitral Valve Prolapse
- ❑ Multiple Sclerosis
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio/Mumps/Chicken Pox
- ❑ Prostate Problems
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Sexually Transmitted Disease
- ❑ Others: _____

History of Any Blood Product Transfusions/Date: _____

ALLERGIES/ADVERSE REACTIONS (Medicine, Food, etc.)_____

_____

MEDICATIONS (Dosage, Frequency): Please include over-the-counter products

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you taking? ___Aspirin products ___Arthritis/Anti-inflammatory ___Blood Thinner

Vitamins_____

NAME: _____

HEALTH HABITS	None?	How much?	How often?	How long?	When quit?
Tobacco					
Alcohol					
Illicit Drugs					
Coffee					

OCCUPATION: _____ Hobbies _____

FAMILY HISTORY: Significant Medical Condition	Age	If applicable, cause of death
Father		
Mother		
Siblings (Please list all)		

Is there any history of the following in your extended family? (Please circle)

High Blood Pressure Heart Disease Colon Cancer Colon Polyps
Tuberculosis Ulcer Disease Liver/Gallbladder Disease
Diabetes Ulcerative Colitis/Crohn's Pancreatic Disease
Female Cancer (Breast, Ovarian, Endometrial, or Uterine)

SYMPTOMS **(please mark yes or no for each one)**

GENERAL	No	Yes	Comments
Chills/Fever			
Depression			
Fainting/Dizziness			
Loss of weight			
Sweating			
Difficulty sleeping			
Decreased energy			
EYES/EARS/NOSE/THROAT			
Blurred vision			
Double vision			
Eye pain			
Decreased hearing			
Ringing in ears			
Earache			
Runny nose			
Sinus problems			
Mouth ulcers			
Persistent cough			
CARDIOVASCULAR			
Chest pain			
High blood pressure			
Shortness of breath			
Irregular heartbeats			
Palpitation			
Swollen ankles			
Leg cramps			
Heart murmur			
Heart Problem			
RESPIRATORY			
Coughing			
Coughing blood			
Tuberculosis			

	No	Yes	Comments
Asthma			
GASTROINTESTINAL			
Poor appetite			
Trouble swallowing			
Pain with swallowing			
Indigestion			
Heartburn			
Nausea			
Vomiting			
Bloating			
Abdominal pain			
Diarrhea			
Ulcer disease			
Liver disease			
Hepatitis history			
Gallbladder disease			
Lactose intolerance			
Hemorrhoids history			
Bloody bowel movements			
Abdominal swelling			
Jaundice (yellow eyes)			
Constipated			
Using laxatives			
Loss of bowel control			
GENITOURINARY			
Trouble urinating			
Blood in urine			
Frequent urination			
Loss of bladder control			
Sexual problems			
Abortions (Females only)			

NAME: _____

MUSCULOSKELETAL	No	Yes	Comments
Swollen joints	____	____	_____
Joint stiffness	____	____	_____
Muscle pain	____	____	_____
Arthritis	____	____	_____
Back Pains	____	____	_____
Face badly flushed	____	____	_____
Sweating often	____	____	_____
Skin rash	____	____	_____
Itching	____	____	_____
Breast mass/discharge	____	____	_____
NEUROLOGICAL			
Numbness or tingling	____	____	_____
Part of body paralyzed	____	____	_____
Seizure history	____	____	_____
Severe headaches	____	____	_____

PSYCHIATRIC	No	Yes	Comments
Feeling depressed	____	____	_____
Crying often	____	____	_____
Easily upset/irritated	____	____	_____
Frequent nightmares	____	____	_____
Frequently nervous	____	____	_____
Thinking about suicide	____	____	_____
ENDOCRINE			
History of goiter	____	____	_____
Problems with calcium	____	____	_____
Problems with glands	____	____	_____
HEMATOLOGIC/LYMPHATIC			
History of anemia	____	____	_____
Swollen lymph glands	____	____	_____
History of tumor/cancer	____	____	_____
Bruise/bleed easily	____	____	_____
ALLERGIC/HEMATOLOGIC			
Hayfever	____	____	_____
Hives frequently	____	____	_____
Allergies to foods	____	____	_____

Completed by _____ **(If not by patient) Relationship to Patient** _____

Please sign _____ **Date** _____

Please make sure you have signed and dated each page

Reviewed by _____ **Date** _____

DHAT

Digestive Health Associates
of Texas, P.A.

Consent for Medical Treatment

I, the undersigned, the patient (or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgement of the physician, his assistants or designees.

I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me as to the result of treatment or examinations performed.

I authorize Digestive Health Associates of Texas, P.A. or staff to retain, preserve and use for scientific or teaching purposes, or dispose of at their convenience and in their sole discretion any specimens or tissues removed and I waive any interest I may have had in such specimen tissues.

This form has been fully explained to me and I certify that I understand and accept its contents.

All the above will be discussed with me, by the attending physician prior to any proposed testing or any type of surgical procedures to be scheduled.

Patient's Signature: _____

Date: _____

DHAT
Digestive Health Associates
of Texas, P.A.

7.30 Patient Authorization for Personal Representative

Please print all information, then sign and date form at bottom.

Type of Authorization: Personal Representative

Patient's name (Please print): _____ **Date of Birth:** _____

Purpose of request: I authorize Digestive Health Assoc. of Texas, P.A. to disclose or provide my protected health information (PHI) to the following individual who is authorized to act as my personal representative for the purposes of receiving all PHI about myself. As my designated personal representative, they may exercise my right to inspect, copy and correct my PHI. They may also consent or authorize the use or disclosure of my PHI:

_____
Name of Personal Representative and Relationship (i.e. Spouse, family member, etc.)

_____
Address

_____
City, State, Zip

_____
Phone

Description of information to be disclosed – I authorize Digestive Health Assoc. of Texas, P.A. to disclose all of my PHI to my designated personal representative.

Circle one: Procedure & Biopsy Labs All Information

Expiration or termination of authorization – This authorization will remain in effect until terminated by patient, the patient's personal representative, or another individual of legal entity authorized to do so by court order of law.

Right to revoke or terminate – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person or by mailing a request to:

DIGESTIVE HEALTH ASSOCIATES OF TEXAS, P.A.
_____
_____
_____
ATTN: _____

Redisclosure – We have no control over the person(s) you have listed as your personal representative. Therefore, your PHI disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Digestive Health Assoc. of Texas, P.A.

7.34 Patient Authorization for Disclosure of Protected Health Information via Alternative Means.

Type of Authorization: Alternative Means

Patient's name (Please print): _____ **Date of Birth:** _____

Purpose of request – I authorize Digestive Health Assoc. of Texas, P.A. to disclose my PHI in the following manner. I understand that it is my responsibility to notify the practice of any change in this manner of communications and that any disclosure made to the designated address number, indicated by me, is subject to the redisclosure statement within this authorization.

(Check the box that applies)

☐ Home Telephone: _____ ☐ Cell Number: _____ ☐ Fax Number: _____

☐ Work Telephone: _____ ☐ US Mail: _____

☐ Email (Physicians & Medical Asst. Only): _____

☐ Leave detailed messages on my answering machine / voice mail

☐ Leave messages with only call-back number (includes staff member name and doctor's office) on my answering machine / voice mail

Expiration or termination of authorization – This authorization will remain in effect until terminated by patient, the patient's personal representative, or another individual of legal entity authorized to do so by court order of law.

Right to revoke or terminate – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person or by mailing a request to:

DIGESTIVE HEALTH ASSOCIATES OF TEXAS, P.A.
_____
_____
_____
ATTN: _____

Redisclosure Statement – I understand that the practice has no control regarding persons who may have access to the mailing address, telephone, cell or fax number I have designated to receive my PHI. Therefore, I understand that my PHI disclosed under this authorization will no longer be the responsibility of this practice.

X _____ _____
Patient's Signature Date

ATTENTION:

IF YOU HAVE ADDITIONAL RECORDS YOU WOULD LIKE US TO HAVE IN ADDITION TO THE RECORDS WE WILL REQUEST FROM YOUR REFERRING PHYSICIAN, PLEASE FILL OUT THE FOLLOWING FORM AND FORWARD TO THE PHYSICIAN YOU WOULD LIKE THE RECORDS OBTAINED FROM.

THANK YOU

DHAT
Digestive Health Associates
of Texas, P.A.

AUTHORIZATION TO REQUEST OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Date of Birth _____

I authorize the following individual or organization to:

Please complete the following two sections:

☐ **Request From**

_____

_____

_____

☐ **Disclose to: Sindhu Abraham, M.D.**
Digestive Health Associates
3242 Preston Rd, Suite 200, Plano, TX 75093
972-867-0019 972-867-7785 FAX

For the purpose of: _____

Please release the following:

___Problem List
___Progress Notes
___History/Physical Exam
___Medication List
___Other (Specify) _____

___X-Ray/Imaging Reports-from (date) _____ to (date) _____
___X-Ray Films
___Laboratory Results-from (date) _____ to (date) _____
___List of Allergies

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
___Yes, I consent to the release of this information. ___ No, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in six months from the authorization date, or on _____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. *I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.* I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact _____.

_____ _____
Signature of Patient or Legal Representative Date

_____ Sabraham MD
Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold ***Digestive Health Associates of Texas, P.A.*** liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

Form 7.31/7.32 Combined

Date request completed_____ # pages copied_____ Reviewed only_____ Charges $_____
Cash_____ Check #_____ Initials_____