HIPAA Authorization for Release of Medical Information

Patient Information

Patient Name:	
Date of Birth:	
Email:	
Phone Number:	

Physician/Healthcare Provider Information

Provider Name:	
Phone:	
Address:	

I hereby authorize my physician/healthcare provider named above to disclose and discuss my medical information related to my diagnosis, treatment, and prescribed medications for Crohn's Disease or Colitis with the **Andrew Durick Foundation**.

I also authorize the Andrew Durick Foundation to contact my physician/healthcare provider for the purpose of:
• Confirming my diagnosis or treatment plan
• Coordinating resources such as food assistance or payment for medication
• Supporting my care needs as outlined in this request

This authorization includes, but is not limited to, the disclosure of:
• Diagnosis and treatment information
• Medication prescriptions
• Recommendations related to my medical care

Terms
• I understand this authorization is voluntary.
• I may revoke this authorization at any time by providing written notice to the Andrew Durick Foundation, except to the extent action has already been taken in reliance on this authorization.
• My healthcare provider cannot condition treatment, payment, or eligibility for benefits on whether I sign this authorization.
• This authorization will remain in effect for **one (1) year** from the date signed, unless revoked earlier in writing.

Signature

Patient/Guardian Name:	
Signature (electronic or handwritten):	
Date:	