



**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**