Release of Information from ADD

I ____ , hereby authorize **Alabama Digestive Diseases, P.C.** to release my medical records to:

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Signature of Patient ____

Date ____

Witness ____

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party who may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.