Center for Digestive Health

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Medical Records Department Fax# 407-447-5224

By Signing this form, I authorize you to release confidential health information about me, by releasing a copy of medical records, summary or narrative of my protected health information, to the physician, person, facility and/or entity listed below.

This is to Authorize Dr._____ to release records.

Patient Name_____

Social Security#_____

Date of Birth_____

TYPE OF INFORMATION REQUESTED

- ❑ **Most Recent Office Notes**
- ❑ **Most Recent Labs/Pathology Reports**
- ❑ **Most Recent Radiology Reports**
- ❑ **All Mentioned Above**
- ❑ **Other_____**

This information is being requested to be disclosed for the following purpose_____

METHOD OF RELEASE

- ❑ **Patient Picked up Records. Date _____**
- ❑ **Faxed Records to Patient.**
  Fax#_____Date_____
- ❑ **Faxed Records to Doctor Office.**
  Dr._____Fax#_____Date_____
- ❑ **Mailed Records to**
  NAME_____
  ADDRESS_____
  _____

I UNDERSTAND THAT THIS AUTHORIZATION:

- **Prohibits further use or disclosure of the information being released beyond the specific limits of this authorization;**
- **Includes all medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition, including psychological or psychiatric impairment, drug use and/or alcoholism or Acquired Immunodeficiency Syndrome (AIDS), or test for infection with Human Immunodeficiency Virus (HIV);**
- **Expires One (1) year from the date of signature or when the care event is complete;**
- **This authorization may be revoked in writing any time prior to submission of records at my request;**
- **I understand that I have the right to a copy of this authorization;**
- **I understand that failure to provide all information may invalidate the authorization;**
- **I understand that any individual may refuse to sign the authorization and by doing so this will not prevent any further treatment;**
- **Information released to third party other than a health care provide may not be subjected to protection under HIPAA laws.**

Signature_____ Date_____

MAIN OFFICE
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Orlando, FL 32803
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Fax (407) 896-9716
1-800-633-4223

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Suite 201
Lake Mary, FL 32746

KISSIMMEE
431 W. Oak Street
Kissimmee, FL 34741

OVIEDO
7432 Red Bug Lake Rd
Oviedo, FL 32765

CLERMONT
1920 Wickham Dr. Suite 325
Clermont, FL. 34711

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7350 Sand Lake Commons Blvd. Suite 2225
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Orlando, FL 32819