



Center for Digestive Health

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

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
1817 N. Mills Ave
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1-800-633-4223

LAKE MARY
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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
255 Citrus Tower Blvd
Suite 207
Clermont, FL 34711