Florida
DIGESTIVE SPECIALISTS
Gastroenterology and Liver Disease Management
5651 49th St. N, Saint Petersburg, FL 33709

Patient Name:	**Date of Birth**

Facility Authorized to Release my Health Information: **Attention:**
Name:

Phone:
Fax:

Agency or Individual(s) Authorized to Receive my Health Information:
Name:

Phone:

Fax:

Health Information that may be used / disclosed is limited to the following:
Routine Record Sets:

☐ Clinic Set (office visit notes, lab results, radiology imaging/reports, medications, pathology reports

☐ Hospital Set (history & physical, discharge summary, operative reports, pathology reports, consultations, emergency progress notes, laboratory reports and radiology reports and imaging)

☐ Billing Records

☐ Copies of films/images

☐ Entire Record

☐ Other Records as specified: _____

Health Information that may be used / disclosed expires in one year unless otherwise documented below:
From (date): To (date):

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s)
☐Treatment/Consultation ☐ Patient Request ☐ Research ☐ Billing

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, including Sensitive Information as indicated above, which was compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

If no specific date or event is noted below, this authorization will automatically ***one year after*** the date of signature. I understand that I have a right to revoke this authorization at anytime, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

Patient's Signature or Legal Representative		**Date/Time**
Relationship to Patient / Authority to Act on Patient's Behalf	Interpreter, if Utilized	**Date/Time**
Witness Signature	**Date/Time**	Expiration Date or Event

All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.