Gastroenterology Associates of S.W. Florida, P.A.

Board Certified in Gastroenterology

REQUEST: RELEASE MEDICAL RECORDS TO

By signing this authorization, I authorize *Gastroenterology Associates* or *Barkley Surgicenter* to use and/or release certain protected health information (PHI) about me.

TO: (Name, Address, Phone of Recipient of Records)

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____Fax:_____ Attn:_____

Note: If requesting to have PHI faxed to a home or work fax line, this is not secure; it may be subject to re-disclosure by the recipient to a non covered entity and may no longer be protected by the federal HIPAA Privacy Rule. We recommend the PHI be mailed or picked up personally at our office

RECORDS FROM: (Who is Releasing the Records)

Name: Gastroenterology Associates of S.W. Florida, PA
4790 Barkley Circle, Bldg. A., Ft Myers, Florida 33907
Phone: 239-275-8882 Fax: 239-275-6572

Information will be used or disclosed for the following purpose:

- ☐ Continued Medical Care
- ☐ Personal Information
- ☐ Disability Insurance
- ☐ Legal Follow-up
- ☐ Other Specified Reason: _____

The following I authorize to be used or disclosed:

(Specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.)
By checking the boxes below, I specifically authorize the use and/or disclosure of my health information and/or medical records, if such information/records exist:

- ☐ All Records: From_____To_____
- ☐ Specific Request
- ☐ Discharge Summary
- ☐ Operative Reports
- ☐ Emergency Records
- ☐ Pathology Reports
- ☐ Dictated Consults
- ☐ Radiology Reports
- ☐ Physicians Orders
- ☐ Laboratory Reports
- ☐ Progress Notes
- ☐ EKG Reports
- ☐ Other _____

The following specified information MUST be initialed to be included in the use or disclosure:

_____HIV/AIDS related information
_____HBV, HCV, TB or other communicable diseases
_____Genetic Testing Information and/or Records
_____Mental Health Information and/or Records
_____Domestic Violence
_____Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much & what kind of information to be disclosed)
(Specify:_____)

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. **I also understand** that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so. **I, further understand** that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization. **Finally, I understand** that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

Gastroenterology Associates of S.W. Florida, PA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Signed by:

_____ **Signature of Patient or Legal Guardian**

_____ **Date of Birth and Account Number**

_____ **Patient's Name (Print)**

_____ **Social Security Number (Last Four)**

_____ **Witness**

_____ **Date**