Mid-Florida Gastroenterology Group, P.A.

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_______________________________ _______________________________ ___/____/______
Patient Name (Print) Social Security # Patient DOB

_____ I authorize Mid-Florida Gastroenterology Group, P.A. to use or release/disclose my health information as described below.

Please identify the information to be released (check):

_____ Please release my entire record

-OR-

_____ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):

____ Office Notes: ____

____ Procedure Reports: ____

____ Radiology Tests: ____

____ Lab results: ____

____ X-Ray and imaging reports: ___________________________________

____ Other (please describe): _____________________________________

The identified information will be used for the following purpose (check):

____ My personal records

____ Sharing with other health care providers as needed

____ Other (please describe): _____________________________________

By my signature below I indicate my understanding to the following:

--- I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

--- I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

--- I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy.

--- I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual(s) or organization(s):

Name: ____________________________ Name: ____________________________

Phone#_____________Fax#____________ Phone#______________Fax#___________

This authorization will expire on (indicate date): ______________________________

If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

____ _____/_____/_____
Patient Signature (or Signature of Person Completing form if Not Patient*) Date

*Relationship to patient: ____Parent ___Legal Guardian ___ Other: _______________

PLEASE FAX RECORDS TO: <u>(407) 321-7690</u>