**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

|  |
| --- |
| **Patient Information** |
| Name: Date of Birth: |
| Address: |
| City: State: Zip: |
| Phone Number: |

I authorize Digestive Disease Consultants to: □ Disclose to □ Obtain from

|  |
| --- |
| Name: |
| Address: |
| City: State: Zip: |
| Phone Number: |
| Fax Number |

Purpose for Release:

□ Personal Request □ Continuation of care □ Transfer of care to another physician or hospital

□ Location/Moved □ Referral to another Physician □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the following information to be disclosed:

□ Complete Chart □ History & Physical □ Laboratory Results □ Procedure Report □ Pathology Report □ Radiology Report

As required by state and federal law, Digestive Disease Consultants, may not use or disclose your health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the use and disclosure of the protected health information described on this form.

* I understand that the protected health information specified above may also include mental health, substance abuse (e.g., drugs, alcohol) and HIV/AIDS status information.
* I understand that I may revoke this authorization at any time by notifying the Health Information Management department in writing.
* I understand the information disclosed may be subject to redisclosure and no longer be protected by federal and state privacy laws.
* I understand that I am signing this voluntarily and I am signing this under my own free will. Digestive Disease Consultants will not condition my treatment by signing this form.
* I realize there are inherent risks in faxing Protected Health Information.
* I understand per the Florida Statute “Fee: $1.00 per page for the first 25 pages, $0.25 for any pages over 25, plus postage.
* I understand that I will receive a signed copy of this form.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_