DR.ROSADO DR.VILLANUEVA DR.CAVACINI DR.SOROKA DR.GASSERT DR.BARLOW DR. AHMADI DR.McGAW

Gastroenterology Associates 216 Southpark Circle E., St. Augustine, FL 32086
St. Augustine Endoscopy Center 212 Southpark Circle E., St. Augustine, FL 32086
Tel (904) 824-6108 **Fax (904) 823-9613**

PATIENT REQUESTING OUTGOING MEDICAL RECORD RELEASE

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____ Home Phone _____

City State Zip

I, _____, do hereby consent to and authorize ( ) Gastroenterology Associates of St. Augustine, P.A.
Patient's Name/Guardian
( ) St. Augustine Endoscopy Center

to disclose to: ( ) Self_____, _____,
Name of Provider/Hospital/Insurance Company/Other Agency Attention to

at _____ for the purpose of _____
Provider/Hospital/Insurance Company/Other Agency's Address

my individually indentifiable health information (protected health information) as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Attention Patient

Please be alerted that, if any one of the following three (3) boxes are checked, it is with the intention of making you aware that your record(s) contains "PROTECTED" information related to these categories. If you are authorizing the release of this protected information, your signature, next to the identified category, is required.

_____ ☐ **Drug & Alcohol Abuse Control Act 42 CFR part 2**
Signature/Date/Time

_____ ☐ **Mental Health Procedure Act**
Signature/Date/Time

_____ ☐ **Confidentiality of HIV-Related Information Act**
Signature/Date/Time

I understand that my record may contain:
Drug or alcohol information, if drug or alcohol tests were ordered or treatment provided by my physician.
Psychiatric or psychological information, if psychiatric or psychological treatment was given by my physician;
HIV related information, if HIV-related tests were ordered by my physician;

The information to be released is:

☐ History & Physical ☐ Pathology Report ☐ GI Operative Reports ☐ X-ray Report
☐ Discharge Summary ☐ Consultation Report ☐ Laboratory Results ☐ Other (Please Specify) _____

☐ EXCEPTION: I do not give permission to release (please specify): _____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation. **Initials**: _____
I understand that my authorization will expire on _____/_____/____ or 90 days from date of my request. **Initials:** _____

_____ _____ _____ _____
Signature of patient or patient's representative Printed name Relationship (if applicable) Date/Time

(this form MUST be completed before signing)

_____ _____
Witness to Signature Date/Time

☐ Unable to sign because: _____

PATIENT ☐ received ☐ refused a copy of this form Date Information Released _____ Intials _____