WESTCHASE GASTROENTEROLOGY

Authorization for Release of Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

Previous Name, if applicable: _____ SSN #: _____

☐ I hereby authorize the release of my PHI from: **WESTCHASE GASTROENTEROLOGY**

☐ 4695 Van Dyke Road Lutz, FL 33558 ☐ 11912 Sheldon Road Tampa, FL 33626 ☐ 508 S Habana Avenue, Suite 270 Tampa, FL 33609

Telephone: 813.920.8882 Fax 813.920.8883

For the purpose of: ☐ Continuity of Care ☐ Personal Records ☐ Transferring Out of Practice

☐ Other, specify: _____

You may disclose the following PHI: ☐ Complete Medical Records ☐ Progress Notes ☐ Laboratory Reports ☐ Pathology Reports ☐ Procedure Reports ☐ Date(s) of Treatment: _____

☐ Other, specify: _____

HIV, Mental Health and Drug & Alcohol Information contained in my medical record will NOT be released WITHOUT my authorization.

I authorize the disclosure of: ☐ HIV ☐ Mental Health (Psychiatric) ☐ Drug & Alcohol – **Patient Initials: ____**

Please send records to:

Name of Organization: _____

Organization Address: _____

Organization Phone #: _____ **Fax #:** _____

This authorization ends: ☐ **On date:** _____

☐ This authorization will expire automatically when the records requested on this form have been sent to the requestor or within 120 days from the date of signature, whichever comes first.

Westchase Gastroenterology reserves the right to charge a fee for copying medical records. Please allow 5-7 business days from date of request for processing and completion of your request.

Patient Rights: I understand I do not have to sign this authorization in order to receive health care services. However, I do have to sign an authorization form when the purpose is to provide my PHI for a third party. I understand that I may revoke this authorization at any time by submitting a written letter to the named practice listed above, if I do, it will not affect any actions already taken. I understand that once my PHI has been disclosed to the named person/organization in this authorization, HIPPA laws may no longer protect it, and the named or person/organization may re-disclose it.

Patient or Legal Representative Signature Date Signed

Print Name Relationship to Patient