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:

Name of Person/Organization: _____

Person/Organization Address: _____

Person/Organization Phone #: _____ **Fax #:** _____

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

☐ Other, specify: _____

You may disclose the following PHI: ☐ Complete Medical Records

☐ Laboratory Reports ☐ Pathology Reports ☐ Procedure Reports ☐ Progress Notes ☐ Radiology 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:

WESTCHASE GASTROENTEROLOGY
11912 Sheldon Road, Tampa FL 33626
Telephone: 813.920.8882
Main Fax: **813.920.8883** Alternate Fax: **813.920.5800**

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, HIPAA 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 if signed on behalf of patient Relationship to Patient