CFAGI

Center for Advanced Gastroenterology

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ DOB _____ SS# _____ Chart#_____

Medical Records To:	**Medical Records From:**
_____	_____ _____
Address: _____	**Address:** _____
Phone #: _____ **Fax #:** _____	**Phone #:** _____ **Fax #:** _____

☐ Complete Records ☐ Face Sheet ☐ History & Physical
☐ Labs/X-Rays ☐ Consultations ☐ Itemized Bill
☐ Other _____

Purpose for Release:
☐ Continuation of care
☐ Transfer of care to another physician or hospital
☐ Personal copy
☐ Location / Moved
☐ Referral to another Physician

☐ Other (please specify) _____

As required by state and federal law, Center for Advanced Gastroenterology, PLLC, 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 state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorization, Center for Advanced Gastroenterology cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition. I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to Center for Advanced Gastroenterology, 740 Concourse Parkway South Ste 200 Maitland, FL 32751, I further understand that any such revocation does not apply to information already released in response to this authorization. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization. I understand that I have a right to inspect and to obtain a copy of any information disclosed. The undersigned hereby authorizes Center for Advanced Gastroenterology to release any and all information contained in the records of the patient listed above, INCLUDING INFORMATION REGARDING DRUG AND /OR ALCOHOL TREATMENT, PSYCHOLOGICAL AND SOCIAL SERVICES RECORDS, COMMUNICATIONS MADE TO A SOCIAL WORKER, PSYCHOLOGIST, OR PSYCHIATRIST, AND HIV/AIDS-RELATED COMPLEX DOCUMENTATION, to the individual(s) or organization(s) listed above. I hereby release Center for Advanced Gastroenterology and it's employees from any and all legal liability that my arise from the release of information as I have directed. I understand that I may be charged a fee up to $1.00 per page (plus applicable tax and handling) for every page copied. This fee is waived for copies provided to a health care provider for continuing medical care. I understand that this fee is within the limits allowed by Florida law. I hereby authorize Center for Advanced Gastroenterology to release my health information as described above.

Patient Signature _____ Date _____

Signature of Parent or Guardian _____ Date _____

Relationship of Patient _____