



Digestive and Liver Center of Florida

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I (Patient Name, printed) _____ **Date of Birth:** _____ hereby authorize the disclosure of the protected health information described below. I understand that this authorization is voluntary. I understand that if the organization I authorize to receive the information is not a health plan or health care provider, federal or state law may no longer protect the released information and it will no longer be private.

TO: (Name and address of who is providing the Information) _____

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

Name and address of who will receive the Information: _____

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

Specific Description of Information: _____

The information is being requested for the following reason: (Filled out by requestor)

Treatment? _____ **Other?** _____ (explain below):

- ✓ I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any effect on any actions they took before they received the revocation.
- ✓ I understand that my health care and the payment for my health care won't be affected if I don't sign this form.
- ✓ I understand that I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
- ✓ I understand I have the right to refuse to sign this authorization.

Please return completed form to: Digestive and Liver Center of Florida, 100 N. Dean Road, Suite 101, Orlando FL 32825

Digestive and Liver Center of Florida, recognizes a patient's right under HIPAA to access copies of his/her health information. **Please allow 24 to 48 hours to process your request.** There may be a charge associated with processing a request and producing requested records.

This authorization will be in force until **Date:** ____/____/____ or (event) _____ at which time it expires. (**Required** – you **must** specify a date or event. **Lifetime** not valid)

Signature of Patient or Patients Representative

Date

(Form MUST Be Completed Before Signing)

Printed Name of Patient's Representative: _____

Relationship to Patient: _____

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