GASTROENTEROLOGY ASSOCIATES
OF FLORIDA
powered by GI Alliance

Authorization for Disclosure of Health Information

Patient Name: _____ DOB: _____

Account Number: _____ Provider: _____

I hereby authorize _____ to release my protected health information to:

Gastroenterology Associates of Florida
1397 Medical Park Blvd, Suite 300
Wellington, FL 33414
Fax: (561) 964-7393 Phone: (561) 964-8221

The information to be disclosed is as follows:

- ☐ Colonoscopy/EGD/Flex/ERCP Reports
- ☐ Pathology Reports
- ☐ Lab Reports (withing last 1 year)
- ☐ Other: _____
- ☐ Radiology Reports (CT, US, XR, MRI)
- ☐ Consultation Reports / Office Notes
- ☐ Operative/Procedure Reports

I certify that this request has been made freely, voluntarily without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I may receive a copy of this form after I sign it upon request.

I understand that I have a right to revoke this authorization at any time, in writing, addressed to *Gastroenterology Associates, Attn: Medical Records*. Revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that my health record may include specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection. ***IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL: DO NOT RELEASE: _____***

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF THE INFORMATION REQUESTED ABOVE

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____
PRINTED NAME OF PATIENT OR LEGAL GUARDIAN