Digestive Diseases Associates of Tampa Bay, LLC
876 South Parsons Ave., Brandon, FL 33511
Tel: 813-653-3359 Fax: 813-662-9639

Send completed form by one of the following: ***Fax****: (813) 662-9639* ***Mail****: address above* ***Drop Off***
I would like to receive my records by (check one): ☐ *Mail* ☐ *Pick Up* ☐ *Unsecured email*

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT			
DATE OF BIRTH		SS#	

TO: (Name, Address, Phone of **Recipient** of Records)						
Name				Phone		
Address				Fax		
City/State Zip	City		State		Zip	

RECORDS FROM: (Who is **Releasing** the Records)						
Name				Phone		
Address						
City/State Zip	City		State		Zip	

For the Following Purposes:

☐	Continued Medical Care	☐	Personal Information	☐	Legal Follow-up
☐	Disability Insurance	☐	Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

☐	Please send the entire Medical Record (all information) to the above named recipient.				
☐	Office Notes and Reports	☐	Diagnostic Reports	☐	Billing Statements
☐	Rx History	☐	Transcribed Hospital Reports	☐	Laboratory Reports
☐	Others Listed Here:				

You must check "yes" or "no" if you authorize the release of Sensitive Protected Health Information, test results, records or communications specific to:

	Yes	No
HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases	☐	☐
Mental Health Information and/or Records	☐	☐
Domestic Violence	☐	☐
Genetic Testing Information and/or records	☐	☐
Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind information is to be disclosed.) Describe:	☐	☐
Other:		

I understand that the information outlined in this release will be disclosed according to the instructions of this release with fourteen (14) business days of having received this release authorization.
I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.
I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.
Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Personal Representative: _____

Print Name of Personal Representative (if applicable): _____

Relationship to patient: _____