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Digestive Diseases Associates of Tampa Bay, LLC

Send completed form by one of the following: **Email:** dsilva@ddaotb.com **Fax:** (813) 662-9639 **Mail:** address above **Drop Off**
 I would like to receive my records by (check one): Mail Pick Up Unsecured email CD Flash Drive

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:

<input type="checkbox"/>	Continued Medical Care	<input type="checkbox"/>	Personal Information	<input type="checkbox"/>	Legal Follow-up
<input type="checkbox"/>	Disability Insurance	<input type="checkbox"/>	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:

<input type="checkbox"/>	Please send the entire Medical Record (all information) to the above named recipient.				
<input type="checkbox"/>	Office Notes and Reports	<input type="checkbox"/>	Diagnostic Reports	<input type="checkbox"/>	Billing Statements
<input type="checkbox"/>	Rx History	<input type="checkbox"/>	Transcribed Hospital Reports	<input type="checkbox"/>	Laboratory Reports
<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Information and/or Records	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>
Genetic Testing Information and/or records	<input type="checkbox"/>	<input type="checkbox"/>
Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind information is to be disclosed.) Describe:	<input type="checkbox"/>	<input type="checkbox"/>
Other:		

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: _____