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

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS/PHI

Patient Name _____ **DOB** _____ **Last 4 SSN** _____

Phone Number _____ **Address** _____

Office/Facility RECEIVING Medical Records **Send By:** ☐ Fax ☐ Mail

Name _____ **Phone** _____ **Fax** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Office/Facility SENDING Medical Records

Name _____ **Phone** _____ **Fax** _____

Address _____ **City** _____ **State** _____ **Zip** _____

For the following purpose(s)

☐ Continued Medical Care ☐ Personal Information ☐ Legal Follow Up
☐ Disability Insurance ☐ Other _____

I authorize Use and/or Disclosure of the following Medical Records and/or PHI

☐ Entire Medical Record ☐ Office Notes and Reports ☐ Diagnostic Reports
☐ Medication List ☐ Transcribed Hospital Records ☐ Laboratory Reports
☐ Billing Statements ☐ Other Records: _____

SENSITIVE PHI I further authorize the release of the PHI below which may be included in my medical records

☐Alcohol/Substance Abuse Treatment ☐ Mental Health Information (Excluding Psychotherapy)
☐ STD/HIV/AIDS-related information ☐ Psychotherapy Notes
☐ Genetic Testing ☐ Other
☐ **Do not** release Alcohol/Substance Abuse, mental health, STD, HIV/AIDS, or genetic information

This authorization for Release of Information covers the period of healthcare services rendered from

☐ _____ - _____ ☐ All past, present, and future periods.

1) **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.
2) **I understand** that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.
3) **I understand** that I may refuse to sign this authorization. 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.
4) **I understand** that **I may revoke this authorization**, in writing, at any time, provided I do so in writing to DDA, 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): _____.

_____ _____ _____
Patient's Name: Signature of Patient/Representative Date

_____ _____
Printed Name of Representative Relationship to Patient