Authorization to Disclose Health Information

I, the undersigned, authorize
DIGESTIVE HEALTH PHYSICIANS
7152 Coca Sabal Lane Fort Myers, FL 33908
Phone: 239-939-9939 - Fax: 239-931-5060

to release my health information as noted below:

Patient Information:

Patient Full Name: _____ Other Names During Treatment? _____

Patient Address: _____ Date of Birth: _____

City: _____ State _____ Zip: _____ Phone #: _____

Release Information To:

-This box must be complete in order for request to be processed-

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability
☐ Transfer/Reason_____ ☐ Other_____

Charges outlined below will be applied for all copies released directly to patient and other entities. The charge does not apply when the records are sent directly to a healthcare provider for ongoing treatment purposes.

Information to be Released:

Unless otherwise specified, only the following information will be released:

Abstract includes most recent, up to 2 years: Medical History, Progress Notes, Lab Reports, and Diagnostic Testing.

☐ Please provide a 2 year abstract of my records
*Patient Directive Fees apply

☐ Other - please be specific under comments
Comments: _____
_____
_____

**Patient Directive Fees vary based on page counts and delivery methods.*

☐ **Please check here if you would like your records sent electronically.**
Email Address:
_____

☐ **Please check here if you would like your records sent by mail.**

☐ **Please check here if you would like your records sent on a CD.**

PAYMENT OPTIONS:

CHECK: Please make checks payable to BACTES Imaging Solutions.

CREDIT CARD: Please provide an email address to have an invoice sent. If you do not have an email address, an invoice will be sent to your mailing address .

Authorization to Release Protected:

***Required** - Please read and complete. Check the boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one		*Initial each line below*
I ☐ DO	☐ **DO NOT** want information about ***Mental Health** released	_____
I ☐ DO	☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released	_____
I ☐ DO	☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released	_____
I ☐ DO	☐ **DO NOT** want information about _____ released	_____
	"Other sensitive information?"	

Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature_____**Date:**_____
(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian _____**Date:** _____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- *This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the clinic took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by the clinic and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that I may inspect or copy the information that is used or disclosed.*