DIGESTIVE HEALTH PHYSICIANS

CONSULTATIVE GASTROENTEROLOGY ◆ GASTROINTESTINAL ENDOSCOPY ◆ HEPATOLOGY

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Authorization to Disclose Protected Health Information

Patient's Name: _____ **Date of Birth**: _____

Patient's Address: _____

Social Security Number (last 4 digits only) _____ **DHP Chart #**: _____

Authorization: I _____ hereby authorize Digestive Health Physicians (Drs: Dadrat, Herrera, O'Konski, Penuel, Yudelman. PA-C: Richard Ornato, Tasha Sylva PA-C, John Washington) To REQUEST my medical records FROM:

Name/Facility: _____

Address: _____City: _____State: _____Zip: _____

Phone: _____ Fax#: _____

Purpose of Disclosure: Continued of Care

Please send only the following information for the: ___ Current Year or Last _____ Years (1-10)

_____Office Note _____ Operative Report _____ Pathology Report

_____ Radiology Reports ____Labs _____ Other _____

Patients Signature _____ **Date**_____

This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. I understand that the information used or described pursuant to this authorization may no longer be protected by federal privacy regulations and may be subject to re-disclosure by the recipient. I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I understand that authorizing the disclosure of health information is voluntary. I understand that I may inspect or copy the information that is used or disclosed, for a reasonable copy fee, if I ask for it.

This form is to be kept in patient's permanent medical record. A copy is to be attached to any records disclosed.

FAX RECORDS TO: 239-931-5060

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7152 Coca Sabal Lane,
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3501 Health Center Blvd., Suite 2410,
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