ADVANCED
GASTROENTEROLOGY & HEPATOLOGY
PHONE: 904-513-3998 FAX: 904-575-4919

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _________________Social Security #: _____________Birth Date: ___________

Provider (Who is releasing information): ____

Address: ____

Phone: __________________________________ Fax: _________________________________

I hereby authorize my protected health information from the above provider to be released to:

Recipient's Provider Name (Who is receiving the information):

____

Address: ____

Phone: _________________________________ Fax: ______________________________

The following information may be disclosed (Choose one of the following):

☐ *Specific Medical Records ____

☐ *Other (Specify): ____

*I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information ________ (initial).

I understand that:

1. If the requester or receiver is not a health plan provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. I understand that I may see & obtain a copy of the information described on this form for a reasonable Copy fee, if I ask for it.
5. I may refuse to sign this authorization and that is strictly voluntary.
6. I may retain a copy of this form after I sign it.

Signature of Patient/Legal Representative: _______________________________Date: _______________

(If not signed by the patient) Print Name: ______________________ Relationship to Patient: ___________