Digestive Disease Associates
Medical Records Authorization for Release of Records

Patient Name: _____ Medical Record #/SS#: _____

Date of Birth: _____ Telephone: H: _____ W: _____

Address: _____

The undersigned hereby authorizes the use or disclosure of the above named individual's health information as described below.

The following individual or organization is authorized to make the disclosure:

DIGESTIVE DISEASE ASSOCIATES
6400 W. NEWBERRY ROAD, SUITE 302
GAINESVILLE, FL 32605
PHONE: 352-331-8902 FAX: 352-333-8036

The type and amount of information to be used or disclosed is as follows:

- ☐ All Records
- ☐ 1 year back of office notes and test results (labs, radiology, procedures, etc.)
- ☐ 2 year back of office notes and test results (labs, radiology, procedures, etc.)
- ☐ Specific information: _____

RESTRICTIONS: Only medical records that have originated through this heath care facility will be photocopied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date the patient signed the authorization.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:

Release to: _____ **MAIL** _____

Street Address: _____ **FAX** _____

City, State, Zip: _____ **PICK UP** _____

I understand that I may revoke this authorization in writing at any time, except to the extent that the release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breech of my right to confidentiality. Unless I otherwise revoke this authorization in writing it shall expire on the following date, event, or condition: _____. At that time no express revocation shall be needed to terminate my authorization. I hereby release Digestive Disease Associates of North Florida, Inc. from any legal responsibility or liability for disclosures that may arise as a result of the use of the information contained in the PHI released.

I acknowledge that I have read this authorization and fully understand its contents.

Signed: _____ _____
Patient, Parent or Guardian Date

Witness: _____ _____
Date

Employee Name: _____ Date Received: _____