Gastroenterology Associates of Pensacola
Endoscopy Center of Pensacola

Authorization for Release of Medical Information

Patients Name_____
Last First Middle

Address_____
City State Zip

Date of Birth_____ Social Security Number_____-_____-_____ Telephone Number_____

I hereby authorize and request Endoscopy Center/Gastroenterology Associates (Releasor) to RELEASE a copy of my medical information to:	**I hereby authorize Endoscopy Center/Gastroenterology Associates to RECEIVE a copy of my medical information from:**
Name	Name
Address	Address
City State Zip	City State Zip
Telephone Fax Number	Telephone Fax Number

A copy of the medical records of the above-named patient pertaining to: (Check appropriate box and list date):

- ❑ Emergency Care Date: _____
- ❑ Hospitalization Dates: From_____ to _____
- ❑ Outpatient Care Dates: From _____

SPECIFIC REPORTS REQUESTED:

- ❑ History & Physical
- ❑ Operative Report
- ❑ Discharge Summary
- ❑ Occupational Therapy Notes
- ❑ Lab
- ❑ Physical Therapy Note
- ❑ Pathology
- ❑ X-Ray
- ❑ Abstract (H&P, discharge summary, consult, op report)

The purpose of the requested Medical Records is:

- ❑ at the request of the patient
- ❑ for diagnosis/treatment purposes

other: Explain_____

____I do ____ I do not authorize the release of information, including, if applicable, specific laboratory test of HIV infection (Human Immunodeficiency Virus, the causative agent for AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, all medical records or other information regarding my treatment, hospitalization, including psychological or psychiatric impairment, drug abuse and/or alcoholism or sickle cell anemia.

Releasor, its agents and employees, are hereby authorized to obtain, inspect, and reproduce such records and/or information and are hereby relieved of any responsibility or liability that may arise from the release or reproduction of such records and/or information in accordance with this Authorization. This information can be released/exchanged by FAX, mail or hand delivered. A copy of this authorization can be used as a substitution of the original.

This Authorization will expire one (1) year from the date of my signature.

I understand that I have the right to revoke this Authorization, if the revocation is in writing except if (i) Endoscopy Center/Gastroenterology Associates has taken action in reliance upon this Authorization, or (ii) if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.

I understand that I may revoke this Authorization by providing a written revocation to the Medical Records Department, Endoscopy Center, 4810 North Davis Highway, Pensacola, Florida 32503 or if applicable Gastroenterology Associates, Sacred Heart Division, 5147 North Ninth Avenue , Suite 311, Pensacola, Florida 32504 or Gastroenterology Associate, Baptist Division, 4531 N Davis Hwy, Pensacola, Florida 32503.

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information may no longer be protected by law.

_____/_____ _____/_____
Signature of Patient/Parent/Representative Date Witness Date

_____
Description of Authorized Representative