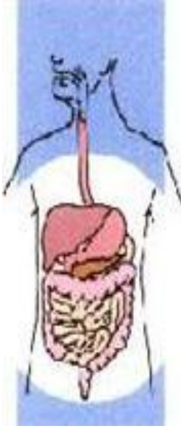

# Digestive and Liver Center of Florida


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## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I (Patient Name, printed) ________________________________________________________________

**Date of Birth:** ________________ hereby authorize the disclosure of the protected health information described below. I understand that this authorization is voluntary. I understand that if the organization I authorize to receive the information is not a health plan or health care provider, federal or state law may no longer protect the released information and it will no longer be private.

**TO: (Name and address of who is providing the Information)** ________________________________________

______________________________________________________________________________________________

**Phone#:**__________________________________________**Fax#:**____________________________________

**Name and address of who will receive the Information:** ______________________________________________

______________________________________________________________________________________________

**Phone#:**__________________________________________**Fax#:**____________________________________

**Specific Description of Information:** ______________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

**The information is being requested for the following reason: (Filled out by requestor)**

**Treatment? ______ Other? ______ (explain below):**

______________________________________________________________________________________________

______________________________________________________________________________________________

- ✓ I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any effect on any actions they took before they received the revocation.
- ✓ I understand that my health care and the payment for my health care won't be affected if I don't sign this form.
- ✓ I understand that I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
- ✓ I understand I have the right to refuse to sign this authorization.

**Please return completed form to: Digestive and Liver Center of Florida, 100 N. Dean Road, Suite 101, Orlando FL 32825**

Digestive and Liver Center of Florida, recognizes a patient's right under HIPAA to access copies of his/her health information.

**Please allow 24 to 48 hours to process your request.** There may be a charge associated with processing a request and producing requested records.

This authorization will be in force until **Date:** _____/_____/_____or (event) ___________________________________ at which time it expires. (***Required** – you **must** specify a date or event. **Lifetime** not valid)*

______________________________________ ______________________

Signature of Patient or Patients Representative Date

**(Form MUST Be Completed Before Signing)**

Printed Name of Patient's Representative: ____________________________________________________________

Relationship to Patient: ________________________________________________________________________