Request: To Release Medical Records To

By signing this authorization, I authorize *Gastroenterology Associates* or *Barkley Surgicenter* to use and/or release certain protected health information (PHI) about me.

TO: (Name, Address, Phone of **Recipient** of Records)

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____Fax:_____ Attn:_____

Note: If requesting to have PHI faxed to a home or work fax line, this is not secure; it may be subject to re-disclosure by the recipient to a non covered entity and may no longer be protected by the federal HIPAA Privacy Rule. We recommend the PHI be mailed or picked up personally at our office

RECORDS FROM: (Who is **Releasing** the Records)

Name: Barkley Surgicenter, Inc.
63 Barkley Cir. Ste. 104, Ft Myers, Florida 33907
Phone: 239-275-8452 Fax: 239-274-3182

Information will be used or disclosed for the following purpose:

- ☐ Continued Medical Care
- ☐ Disability Insurance
- ☐ Other Specified Reason:_____
- ☐ Personal Information
- ☐ Legal Follow-up

The following I authorize to be used or disclosed:

(Specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.)
By checking the boxes below, I specifically authorize the use and/or disclosure of my health information and/or medical records, if such information/records exist:

- ☐ All Records: From_____To_____
- ☐ Discharge Summary
- ☐ Emergency Records
- ☐ Dictated Consults
- ☐ Physicians Orders
- ☐ Progress Notes
- ☐ Other _____
- ☐ Specific Request
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Radiology Reports
- ☐ Laboratory Reports
- ☐ EKG Reports

The following specified information MUST be initialed to be included in the use or disclosure:

_____ HIV/AIDS related information and/or records HBV, TB or other communicable diseases _____Mental Health Information and/or Records
_____Domestic Violence _____Genetic Testing Information and/or Records
_____Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed) Describe:
_____Other:_____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. **I also understand** that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so. **I, further understand** that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization. **Finally, I understand** that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____. Gastroenterology Associates of S.W. Florida, PA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Signed by:

_____	_____
Signature of Patient or Legal Guardian	**Date of Birth and Account Number**
_____	_____
Patient's Name (Print)	**Social Security Number (Last Four)**
_____	_____
Witness	**Date**

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