



Gastroenterology Associates of S.W. Florida, P.A.

Board Certified in Gastroenterology

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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 the party or parties listed below.

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)

The following individually identifiable health information

(Specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.)

- | | |
|---|---|
| <input type="checkbox"/> All Records: From _____ To _____ | <input type="checkbox"/> Specific Request |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Emergency Records | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Dictated Consults | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Physicians Orders | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> EKG Reports |
| <input type="checkbox"/> Other _____ | |

I authorize the following (PHI) information to be released: Please put your initials on next line below:

_____ (Patient initials) Hepatitis C Records, HIV/AIDS Records, Psychiatric / Psychological information/records, Drug/alcohol Treatment

The information will be used or disclosed for the following purpose:

This authorization to release records will expire on _____. If an expiration date is not written it will expire one year from the date signed below.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. I do not have to sign this authorization in order to receive treatment from Gastroenterology Associates or Barkley Surgicenter. In fact, I have the right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed. When my information is used or disclosed pursuant to this authorization, 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. This authorization will expire one year from the date it was signed; However, I have the right to revoke this authorization in writing except to the extent that Gastroenterology Associates or Barkley Surgicenter has acted in reliance upon this authorization. My written revocation must be submitted to Security & Privacy Director at 4790 Barkley Circle, Bldg. A Ft. Myers, FL 33907.

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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