



Gastroenterology Specialists

of Southwest Florida

Diplomate, American Board of Internal Medicine and Gastroenterology

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MEDICAL RECORD RELEASE FROM OTHER ENTITY

Authorization of disclosure of protected health information by another covered entity for use by Gastroenterology Specialists of Southwest Florida, P.A. from

Dr's Name _____ Phone _____

Address _____ Fax _____

City, ST, ZIP _____

Medical Information to be released:

_____ office visits (please specify dates) _____ test results (specify)

This authorization shall be in effect until _____ but no longer than one year from the date signed at which time this authorization to use or disclose protected information expires.

I understand that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at 1656 Medical Blvd, Ste. 301, Naples, FL, 34110

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state laws.

I understand that I have the right to refuse to sign this authorization

Signature of Patient or Representative Date

If Representative, relationship _____

Printed name Date of Birth