Digestive Disease Clinic

2400 Miccosukee Road • Tallahassee, FL 32308
(850) 877-2105 • Fax (850) 942-1761

Medical Records Release

_____
Social Security Number

_____
Daytime Telephone Number

_____ _____ (_____)
Name of Patient Date of Birth Maiden Name

Authorize:

Name _____
Address _____
City, State, Zip _____

To Disclose To:

Name _____
Address _____
City, State, Zip _____

❒ On-site review of the above patient's health care records

INFORMATION TO BE RELEASED (Please check appropriate boxes)

❒ Any and all medical records, including MENTAL HEALTH, ALCOHOL AND/OR DRUG ABUSE TREATMENT AND HIV (AIDS) TESTING AND/OR TREATMENT.

❒ The following information MAY NOT be released: ❒ Mental Health ❒ Alcohol and/or Drug Abuse
❒ HIV (AIDS) Testing and/or Treatment ❒ Other: _____

❒ Records confined to the following specific information or condition: _____
_____

❒ Other: _____

This disclosure is being made for the following purpose(s): (check appropriate boxes):

❒ Continuing Care
❒ Attorney/Court Case
❒ Workers' Compensation Case
❒ Transfer of Care / Referral Physician
❒ Insurance
❒ Personal Reasons
❒ Other: _____

This authorization for disclosure of information is effective for 90 days from date signed. This information consent is subject to revocation at any time by written notification only. This office is not responsible for any dissemination or disclosure of your confidential medical information once we provide the information, at your request, to your insurer or other parties.

Patient Signature _____ Date _____

OR Signature of
Legal Representative _____ Date _____

Witness Signature _____ Date _____

Relationship:
❒ Legal Guardian
❒ Executor of Estate
❒ Spouse of Deceased
❒ Power of Attorney for Health Care
❒ Other: _____