AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (MEDICAL RECORD)

_____ **hereby authorizes the use or disclosure of the individually**
Print Patient/Legal Representative or Parent/Legal Guardian Name

identifiable health information of _____ **as described herein.**
Print Patient Name Date of Birth

Organization authorized to **use/disclose** the information:	Person/Organization authorized to **receive** the information:
Children's Center for Gastroenterology and Nutrition	Name/organization _____
7350 Sandlake Commons Blvd., Suite 1100	Address _____
Orlando, FL 32819	City, State, Zip _____
Phone: 407-351-0804 Fax: 407-354-0701	Phone: _____ Fax: _____

For the purpose of: ☐ Legal Request ☐ Moving out of Area ☐ New Local Physician ☐ Other (please specify)

Date(s) of Service: **From:** _____ **To**: _____

This authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand **that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized re-disclosure of my health information.** I further understand that the Children's Center for Gastroenterology and Nutrition may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Place your initials by each item to be released or reviewed:

____ Complete Record
Or
____ Abstract of Record

____ All diagnostic test results
____ Consultation/Progress Note(s)
____ Radiology only

____ Pathology/Operative Report(s)
____ Lab only
____ Other (please Specify) _____

In addition, place your initials by each specific item: (if applicable)

____ Mental Health
____ Drug and/or Alcohol

____ HIV Testing
____ AIDS Information

____ Genetic Counseling/Testing Information

_____ _____
Patient/Legal Representative or Parent/Legal Guardian ***Signature Required*** Date of Authorization

_____ _____ _____
Date of Birth Social Security Number (optional) Identification Shown

_____ _____
Translator or Interpreter's Name Telephone Number

_____
Address City State Zip Code

Official Use Only: _____
Name of Person Releasing Information **Date**