



CONSULTATIVE GASTROENTEROLOGY ♦ GASTROINTESTINAL ENDOSCOPY ♦ HEPATOLOGY

Authorization to Transfer Medical Records

Patient's Name _____ Date of Birth _____

Social Security Number (4) ____ _ DHP Patient Number _____

1. Authorization for release: I hereby authorize Digestive Health Physicians, PL (Drs. Dadrat, Herrera, O'Konski, Penuel, Yudelman & Richard Ornato) to release, disclose and deliver medical records and/or information, including any HIV (AIDS) information to: Authorized Recipient:

Self "Patient" _____

Name: _____ Name: _____

Fax: _____ Fax: _____

Please send the following information:

Complete Record ____ Operative Report ____ Pathology Report ____ Reports(s) from last ____ yr(s)

2. Specific Authorization: I specifically authorize the release of all medical information relating to me including but not limited to the following categories protected by state or federal law: 1) substance (drug or alcohol) treatment; 2) mental health treatment, and 3) HIV/AIDS-related information, if such information is contained in my records. I do not give permission for any other use or re disclosure of this information.
3. Redis closure: this release does not authorize re disclosure of medical information beyond the limits of this consent. The Recipient of this information is prohibited from using the information for other than stated purpose, and from disclosing it to any other party. This information has been disclosed to your from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I specifically understand and agree that the re disclosure requirements set above will apply to these records.
4. Validity: I understand that this release will automatically expire one year from the date of my signature, and that I may revoke this release by sending a written notice to the person or entity authorized to make the disclosure above. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

I authorize the release of information as indicated above.

Patients Signature _____ Date _____

Patients Address _____

This form is to be kept in patient's permanent medical record under administration tab. A copy is to be attached to any records disclosed.

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