CENTRAL FLORIDA GASTROENTEROLOGY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

SS#: _____ DOB: _____

_____
Physician/facility

☐ *receive records from:*

☐ *release records to:*

_____
Address

_____
City, State, Zip

_____
Phone *Fax*

☐ *receive records from:* RICHARD DUMOIS, MD

☐ *release records to:* 6735 CONROY ROAD, SUITE 214
ORLANDO, FL 32835
PHONE: (407) 395-7040 FAX: (407) 395-7105

This document authorizes the release of all medical records in your possession regarding care and treatment of above mentioned patient. Please send records pertaining to the following:

____ Office notes and reports ____ Diagnostic imaging results ____ Transcribed hospital reports

____ Lab results ____ Others _____

I understand these records may contain information from other health care providers as well as information that is administrative in nature.

I specifically consent to the release of any information contained in the medical records which may relate to (the following items must be initialed to be included in this disclosure):

____ HIV/AIDS related information and/or records HBV, TB, or other communicable diseases
____ Mental health information and/or records
____ Genetic testing information and/or records
____ Drug/alcohol diagnosis, treatment, or referral information (Federal regulations require a description of the type of information to be disclosed.) Describe: _____

I understand that if the person or entity receiving the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.
Finally, I understand that I may revoke this authorization in writing at any time provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire in six (6) months from the date of signing.

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified above:

_____ _____
Print Patient's Name or Legal Representative Date

_____ _____
Signature of Patient or Legal Representative Relationship to Patient