# HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

PATIENT NAME: _____

DOB: _____ SSN: _____ PHONE: _____

I, _____AUTHORIZE _____
TO RELEASE:

☐ MY ENTIRE MEDICAL RECORD

☐ ONLY THE FOLLOWING RECORDS OR DATES :

_____

_____
TO THE FOLLOWING PARTY:

☐ MYSELF

☐ TAMPA BAY REFLUX INSTITUTE, 1315 SOUTH HOWARD AVE, SUITE 101, TAMPA, FL 33606 FAX: (813) 742-0711

☐ OTHER:

_____
NAME ADDRESS

_____
PHONE FAX EMAIL

I UNDERSTAND THE FOLLOWING:

1. I MAY REFUSE TO SIGN THIS AUTHORIZATION AND THAT IT IS STRICTLY VOLUNTARY
2. MY TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION
3. I HAVE A RIGHT TO REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT INFORMATION HAS BEEN RELEASED IN RELIANCE UPON THIS AUTHORIZATION
4. I UNDERSTAND THAT I AM ENTITLED TO A COPY OF THIS AUTHORIZATION UPON SIGNATURE, IF I ASK FOR A COPY AND FOR A REASONABLE COPY FEE.

THIS AUTHORIZATION WILL LAST INDEFINITELY UNLESS THIS OFFICE IS NOTIFIED IN WRITING ABOUT ANY NEW CHANGES

PATIENT SIGNATURE: _____

OR SIGNATURE OF LEGAL REPRESENTATIVE: _____

IF SIGNED BY A LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT: _____

DATE: _____