NORTH FLORIDA ENDOSCOPY CENTER

6400 W. Newberry Road Suite201 Gainesville, Fl.32605
Phone 352-333-5900 Fax352-333-5901

Authorization for Release of Protected Health Information (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	**Birth Date:**	**Last 4 digits SSN (optional)**
Provider's/Health Plan Name: North Florida Endoscopy Center	**Recipient's Name:**	
Provider's/Health Plan's Address: 6400 W. Newberry Rd Suite 201 Gainesville, FL 32605	**Address 1:**	
	Phone #:	
	City:	**State:** **Zip:**

This authorization will expire on the following; (fill in the Date or the Event but not both)

Date: **Event:**

Purpose of Disclosure:

Description of information to be used or disclosed

Description:	Dates:	Description:	Dates:
☐ All PHI in medical record ☐ Dictation Reports ☐ Physician Reports ☐ Lab work ☐ Medication Sheets ☐ Rhythm Strips ☐ Discharge Instructions		☐ Nursing Information ☐ Transfer Forms ☐ Subjective History ☐ Procedure Reports ☐ PACU Record ☐ Other	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information ________(Initial) If not applicable , check here ☐

I understand that:

1. I may refuse to sign this authorization and that is it strictly voluntary
2. My treatment, payment, enrollment or eligibility for benefits my not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice Of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of the PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No

If yes, the health plan or health care provider must complete section B, otherwise skip to section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated:

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Print Name of Patient/Plan Member's Representative:	Relationship to Patient/Plan Member:

Rev 6/17/15 ______Photo ID Verification