Florida Digestive Specialists

Gastroenterology and Liver Disease Management
Over 30 Years of Service

5651 49th Street North
St. Petersburg, FL 33709
Phone: (727) 443-4299

1417 S. Belcher Road, Suite A
Clearwater, FL 33764
Fax: (727) 443-0255

RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION	NAME: _____ DOB: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____
Clinic/Hospital/Health Care Provider (**Who** has the information you want released?) **Please list specific Hospital and/or clinic**	NAME: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____
Receiving Party (**Where** do you want the information sent? **Who** may have the information?)	NAME: _____ Attention to: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Fax Number: _____
Information to be Released (**What** do you want sent or released? Check the appropriate box)	Routine Record Sets (Indicate date(s) of service _____ ☐ Clinic (office visit, lab, radiology, medications, immunizations) ☐ Hospital (history and physical , discharge summary, operative report, consultations, emergency, laboratory, radiology) ☐ Billing records ☐ Copies of Films/Images ☐ Any and all records (includes ALL types of records listed below. If you want to include images and billing records, check those boxes. **Only records checked below:** ☐ Discharge summary/note ☐ History and Physical exam ☐ Operative report ☐ Radiology Reports ☐ Laboratory Reports ☐ Progress Notes ☐ Pathology Reports ☐ Medication records ☐ Consults ☐ Other records specified _____ Date information is needed: _____
Purpose of Release	☐ Continuation of care

Jay Kamath, M.D.
Gastroenterologist

Lina Hernandez, ARNP-C
Nurse Practitioner

Sally Follett, ARNP-C
Nurse Practitioner

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	• This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____ • This authorization may be cancelled at any time. A cancellation will not change releases that happen before the cancellation. • A photocopy or fax will be treated in the same way as an original. • Florida Digestive will **NOT** include information received from other organizations. • Florida Digestive Specialists cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Florida Digestive Specialists from any and all liability resulting from a redisclosure by the recipient. • Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

_____ _____
Patient Signature Date

_____
Authority to act on behalf of patient (Attach Document)

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