

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

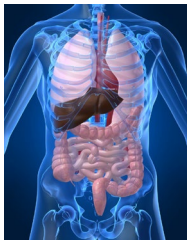
RELEASE OF MEDICAL RECORDS

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 _____) <input type="checkbox"/> Clinic (office visit, lab, radiology, medications, immunizations) <input type="checkbox"/> Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology) <input type="checkbox"/> Billing records <input type="checkbox"/> Copies of Films/Images <input type="checkbox"/> 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: <input type="checkbox"/> Discharge summary/note <input type="checkbox"/> History and Physical exam <input type="checkbox"/> Operative report <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Progress Notes <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Medication records <input type="checkbox"/> Consults <input type="checkbox"/> Other records specified _____ Date information is needed: _____
Purpose of Release	<input type="checkbox"/> Continuation of care

Jay Kamath, M.D.
 Gastroenterologist

Lina Hernandez, ARNP-C
 Nurse Practitioner

Sally Follett, ARNP-C
 Nurse Practitioner



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	<ul style="list-style-type: none">• 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.
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Patient Signature

Date

Authority to act on behalf of patient (Attach Document)

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