Total Gastroenterology, P.A.

Bahram Ahmadi, M.D.
Board Certified in Gastroenterology

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____
Date of Birth: _____ SS#: _____

Address: _____
City:_____ State: _____ Zip: _____

I authorize the use and/or release of my protected health information as described below. I understand this authorization is voluntary and is made to confirm my instructions. I also understand that specific inform to be released may include but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental/psychiatric related illness or communicable disease, including HIV and AIDS.

INFORMATION TO BE RELEASED

Entire Medical Record Progress Notes

Pathology Reports Lab Reports Other(Specify): _____

PURPOSE OF DISCLOSURE

Continuity of Care Personal Copy

Transfer to New Physician Legal Reasons

Other(Specify): _____

RELEASING Organization:
_____
_____
_____
_____
_____

SEND TO:
TOTAL GASTROENTEROLOGY
8610 E. State Road 70
Bradenton, FL 34202
T: 941-242-1929
F: 941-242-5116

SIGNATURE

I have had full opportunity to read and consider the contents of this Authorization, and I confirm that the contents are consistent with my direction to the health care provider. I understand that, by signing this form, I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form. I also understand that specific information to be released may include but is not limited to history, diagnosis, and/or treatments of drug or alcohol abuse, mental/psychiatric related illness or communicable disease, including HIV and AIDS.

Signature of Patient: _____ Date: _____
Name of Legal Guardian: _____
Signature of Legal Guardian: _____ Date: _____