



1268 Highway US 1 Rockledge, FL 32955 Tel (321) 433-3000 Fax (321) 433-3001 www.drseara.com

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTY

The purpose of the disclosure: Request of Individual Referral to Specialist Insurance Referral to Specialist Insurance Regulation Other: (specify) authorization will expire 12 months from the date of patient's signature. In my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revok orization in writing except to the extent that Francisco Aguilo-Seara, M.D., LLC had acted in reliance authorization. My written revocation must be submitted to Francisco Aguilo-Seara, M.D., LLC's office 3 N. Highway US 1, Rockledge, FL 32955. undersigned understands that this consent will continue until the undersigned revokes the consent, we be done at any time by giving written notice of such revocation, except to the extent that the Practice addy made disclosure(s) in reliance upon my prior consent, or as it is required through its contract with rance company or other third-party payer for the payment of claims submitted on my behalf that continue unresolved, and/or for audit requirements by my insurance company or other third-party payer.	tient Full Name (PRINT)		SS#		DOB
Name of Organization: Address of Organization: Phone Number of Organization: Fax Number of Organization: Phone Number of Organization: Fax Number of Organization: Be information to be disclosed relates to service dates beginning Be Intire Medical Record Be Physician Office Notes Colonoscopy Report(s) Pathology Report(s) Change of GI Doctor Reason: Reason: Reason: Beferral to Specialist Insurance Region of the disclosure: Region of the disclosure of	(CHECK ONE) TO	the Indiv	idual, Facility or Compa	any	listed below.
Address of Organization: Phone Number of Organization: Fax Number of Organization: Fax Number of Organization: Be information to be disclosed relates to service dates beginning Be Entire Medical Record Physician Office Notes Colonoscopy Report(s) Pathology Report(s) Pathology Report(s) Results (lab, xray, etc.) The purpose of the disclosure: Request of Individual Reason: Referral to Specialist Insurance Referral to Specialist Insurance Results (lab, xray, etc.) The purpose of the disclosure: Referral to Specialist Reason: Referral to Specialist Results (lab, xray, etc.) The purpose of the disclosure: Reason: Referral to Specialist Reason: Referral to Specialist Reason: Referral to Specialist Results (lab, xray, etc.) Workers Compensation Reason: Results (lab, xray, etc.) The purpose of the disclosure: Reason: Referral to Specialist Reason: Results (lab, xray, etc.) Workers Compensation Reason: Reason: Results (lab, xray, etc.) Workers Compensation Reason: Reason: Results (lab, xray, etc.) Workers Compensation Reason: Results (lab, xray, etc.) Workers Compensation Reason: Results (lab, xray, etc.)					
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Entire Medical Record	Fax Number of Organization:				
Upper Endoscopy Report(s) Pathology Report(s) Test Results (lab, xray, etc.) The purpose of the disclosure: Request of Individual Reason: Referral to Specialist Insurance Legal Investigation Other: (specify) authorization will expire 12 months from the date of patient's signature. In my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure ecipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revok orization in writing except to the extent that Francisco Aguilo-Seara, M.D., LLC had acted in reliance authorization. My written revocation must be submitted to Francisco Aguilo-Seara, M.D., LLC's office N. Highway US 1, Rockledge, FL 32955. undersigned understands that this consent will continue until the undersigned revokes the consent, we be done at any time by giving written notice of such revocation, except to the extent that the Practice ady made disclosure(s) in reliance upon my prior consent, or as it is required through its contract with rance company or other third-party payer for the payment of claims submitted on my behalf that contine unresolved, and/or for audit requirements by my insurance company or other third-party payer.	he information to be disclosed relat	es to ser	vice dates beginning		and ending
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