Francisco Aguilo-Seara, MD., LLC

Florida Digestive Health Specialists

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

By signing this authorization, I authorize Francisco Aguilo-Seara, M.D., LLC to use and/or disclose certain protected health information (PHI) about me to or for the party listed below.

Patient Full Name (PRINT) _____ SS# _____ DOB _____

This authorization permits Francisco Aguilo-Seara, M.D., LLC to use or disclose health information
(CHECK ONE) ____ TO the Individual, Facility or Company listed below.
____ FROM the Individual, Facility or Company listed below.

Name, Position, or Department: _____
Name of Organization: _____
Address of Organization: _____
Phone Number of Organization: _____
Fax Number of Organization: _____

**The information to be disclosed relates to service dates beginning _____ and ending _____.**

| | | |
|---|---|---|
| ▫ Entire Medical Record | ▫ Physician Office Notes | ▫ Colonoscopy Report(s) |
| ▫ Upper Endoscopy Report(s) | ▫ Pathology Report(s) | ▫ Test Results (lab, xray, etc.) |

**The purpose of the disclosure:**

| | | |
|---|---|---|
| ▫ Request of Individual | ▫ Change of GI Doctor Reason: _____ | ▫ Workers Compensation |
| ▫ Referral to Specialist | ▫ Insurance | ▫ Legal Investigation |
| ▫ Other: (specify) | | |

This authorization will expire 12 months from the date of patient's signature.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Francisco Aguilo-Seara, M.D., LLC had acted in reliance upon this authorization. My written revocation must be submitted to Francisco Aguilo-Seara, M.D., LLC's office at 1268 N. Highway US 1, Rockledge, FL 32955.

The undersigned understands that this consent will continue until the undersigned revokes the consent, which may be done at any time by giving written notice of such revocation, except to the extent that the Practice has already made disclosure(s) in reliance upon my prior consent, or as it is required through its contract with my insurance company or other third-party payer for the payment of claims submitted on my behalf that continue to be unresolved, and/or for audit requirements by my insurance company or other third-party payer.

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Home Phone — Date