F. Aguilo-Seara, MD., LLC
1268 Highway US 1
Rockledge, FL 32955
Tel: (321) 433-3000 - Fax: (321) 433-3001

Florida Digestive Health Specialists

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

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

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

This authorization permits F. 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	☐ Referral to Specialist	☐ Insurance
☐ Change of GI Doctor Reason: _____	☐ Other Please 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 F. Aguilo-Seara, M.D., LLC had acted in reliance upon this authorization. My written revocation must be submitted to F. 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.

_____ _____

Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____

Printed Name of Patient or Legal Guardian | Date