

Gulf Coast Medical Specialists, PLLC
AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name: _____
Last First Middle

Home Address: _____
Street Address

City State Zip

Telephone: (Day) _____ **(Evening)** _____ **(Cell)** _____ **Date of Birth:** _____

Please send form to: **Gulf Coast Medical Specialists, PLLC**
Medical Records Department
5831 Bee Ridge Road • Suite 210 Phone: **(941) 379-8481**
Sarasota, Florida 34233 Fax: **(941) 379-8142**

SPECIFY INFORMATION TO BE DISCLOSED: _____

RELATING TO THE TIME PERIOD _____ **through** _____

Note: *If your health information contains any genetic, HIV/AIDS-related (i.e., information regarding any HIV related test, infections or illness including AIDS), venereal disease and/or tuberculosis information, you must specifically mention "genetic information," "HIV/AIDS-related information," "venereal disease information" and/or "tuberculosis information," if you want Gulf Coast Medical Specialists, PLLC to disclose such information to any person other than you or your personal representative.*

RECIPIENT: To whom Gulf Coast Medical Specialists, PLLC may disclose my health information:

Name _____

Company _____

Address _____

(If information goes to patient, specify address if different than the one written above.)

PATIENT ACCESS TO INFORMATION:

- I wish to view the requested information.
- I would like to obtain a copy of the information specified above.

TERM: This authorization will remain in effect until the request has been fulfilled unless otherwise noted.

Purpose of Disclosure:

- At the request of the patient (when the patient initiates the authorization)
- Other (please specify) _____

I understand that once Gulf Coast Medical Specialists, PLLC discloses my health information to the recipient, Gulf Coast Medical Specialists, PLLC cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of Gulf Coast Medical Specialists, PLLC's treatment of me except however, if Gulf Coast Medical Specialists, PLLC's treatment of me is for the sole purpose of creating PHI for disclosure to the third person, in which case, Gulf Coast Medical Specialists, PLLC may refuse to treat me if I do not sign this Authorization.

I understand that Gulf Coast Medical Specialists, PLLC may deny my request to have access to my information under limited circumstances permitted by federal regulations governing the protection of personally identifiable health information. I further understand that, except as otherwise permitted under applicable federal law, I have the right to have a denial of my request to have access to my information reviewed by a licensed health care practitioner selected by Gulf Coast Medical Specialists, PLLC who did not participate in Gulf Coast Medical Specialists, PLLC's decision to deny my request.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Gulf Coast Medical Specialists, PLLC's Patient Relations Coordinator at the address listed below. The revocation will be effective immediately upon Gulf Coast Medical Specialists, PLLC's receipt of my written notice, except that the revocation will not have any effect on any action taken by Gulf Coast Medical Specialists, PLLC in reliance on this Authorization before it received my written notice of revocation.

COPY FEES: Copy fees may be applicable according to Florida state mandate.

The address of Gulf Coast Medical Specialists, PLLC's Patient Relations Coordinator is:
5831 Bee Ridge Road, Suite 210 • Sarasota, Florida 34233

and I may contact the ***Patient Relations Coordinator*** by telephone at **(941) 379-8481**.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature I hereby, knowingly and voluntarily, authorize Gulf Coast Medical Specialists, PLLC to use or disclose my health information in the manner described above.

Signature of Patient

Date

If Patient is a minor or is otherwise unable to sign this Authorization, please obtain the following signatures:

Signature of
Personal Representative

Description of Personal Representative's Authority
(i.e., POA, legal guardian-documentation required)

Date

If you have any questions regarding this form, please contact us at 941-379-8481. Thank You.