AUTHORIZATION

Purpose: This form is used by us to have a directive on who is allowed to be given access to your protected health information.

SECTION A: The Individual or Parent/Guardian (If patient is a minor) confirming the authorization.

Name: _____

Address: _____

Telephone: _____ Email: _____

Social Security Number: _____

Yes, you may leave a message on my answering machine or cell phone confirming appointments or other information. Number(s) _____

Please list organizations we may disclose to : (primary care physician, specialists, hospitals, other facilities, etc.),

Pediatric Gastroenterology of Central Florida (Sangeeta Bhargava M.D.)

_____

_____

_____

Please name individuals we may disclose to (List names) : (family members, neighbors, close friends, etc.)

_____

_____

_____

SIGNATURES

I, _____(**Print Name**) 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 you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

I, _____(**Print Name**) acknowledge that I have received Pediatric Gastroenterology of Central Florida, Inc., Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Notice of Privacy Practices.

Signature: _____ Date: _____

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include this authorization in the individual's medical record.
Send copy to the Privacy Officer.