Gastroenterology Specialists
Diplomate, American Board Internal Medicine and Gastroenterology

Steven A. Meckstroth, M.D.
Manuel F. Bustamante, M.D.
William Gonzalez, PA-C
Karina Sejas, PA-C

MEDICAL RECORD RELEASE TO OTHER ENTITY

I, _____ hereby authorize Gastroenterology Specialists of Southwest Florida, P.A. to disclose the following protected health information to:

Dr's Name_____ Phone_____

Address_____ Fax_____

City, ST, ZIP_____

Medical Information to be released:

_____office visits (please specify dates) _____ test results (specify)

This authorization shall be in effect until _____ but no longer than one year from the date signed at which time this authorization to use or disclose protected information expires.

I understand that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at 1656 Medical Blvd, Ste. 301, Naples, FL, 34110. I understand that a revocation is not effective to the extent that Gastroenterology Specialists of Southwest Florida, P.A. has relied on this authorization for the disclosure of the protected health information.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state laws.

Gastroenterology Specialists of Southwest Florida, P.A. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization

_____ _____

Signature of Patient or Representative Date

If Representative, relationship_____