

Section A: This section must be completed for all Authorizations					
Patient Name: *		Birth Date: *		Social Security No. (optional): XXXXXXXXXX	
Provider's Name: Dr. Michael Taylor Phone: (850)784-1856 Fax: (850) 784-1975		Recipient's Name: *			
Provider's Address: Gulf Coast Pediatric & General Surgery 2202 State Avenue, Suite 207 Panama City, FL 32405		Address 1: *			
		Address 2:			
		City: *		State: *	Zip:
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: _____ Event: _____ *					
Purpose of disclosure: *					
*Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:**	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) **					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it.					
Section B: Is the request of PHI for the purpose of marketing?					
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.					
Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?				<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
If yes, describe:					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Patient's Representative: *				Date:	
Print Name of Patient's Representative: *				Relationship to Patient:	