



Pediatric Gastroenterology & Nutrition of Tampa Bay

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ Parent of: _____
(Parent's Name) (Patient's Name)

D.O.B. _____ LAST FOUR OF SS# _____

GIVE: _____

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION REGARDING MY MEDICAL STATUS TO:

(Name)

(Address) (Phone)

THE FOLLOWING TYPES OF INFORMATION ARE SPECIALLY AUTHORIZED FOR RELEASED:

EXPIRATION DATE OF THIS AUTHORIZATION: ____ / ____ / ____

(Patient's Signature)

(Date)

Our Notice of Privacy Practices provides information about our use of a patient's protected health information (PHI). The notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them.