GULF COAST SURGICAL ONCOLOGY

Authorization for Release of Information

Patient's Name: DOB:

Address: City: State: Zip Code:

I hereby authorize and request the release of the following medical records:

☐ History and Physical	☐ Discharge Summary	☐ Imaging Reports
☐ Procedure Reports	☐ Operative Report	☐ Pathology
☐ Laboratory Studies	☐ Consults	☐ Other:

Regarding Date(s) of Treamtent:

The purpose of this request is for (check all that apply):
☐ At the request of the patient ☐ Continuity of Care ☐ Personal ☐ Other:

I Authorize and Request Release of Records by:	To Release to **Gulf Coast Surgical Oncology**
Name:	**Name**: Dr. Leo Villegas
Address:	**Address:**730 Bayfront Pkwy, Suiet 4A
City: **State**: **Zip:**	**City**: Pensacola **State:** FL **Zip**: 32502
Phone: Fax:	**Phone:** 850-432-5488 **Fax:** 850-432-5228

READ CAREFULLY: I understand that my medical records are confidential. I understand that by signing this authorization I am allowing the release of my medical information requested to the agency or person specified above. Drug and alcohol abuse information records are specifically protected by federal regulations and by signing this authorization I am allowing the release of any drug, alcohol and/or psychiatric information records to the agency or person specified above. I understand that my records may contain information regarding the diagnosis and treatment of HIV (AIDS virus) and other sexually transmitted diseases and by signing this authorization, I am allowing this information to be released to the agency or person specified above. I also understand that I may revoke this authorization at any time by written request from myself or my family except to the extent that action has already been taken in reliance upon it.

This consent shall remain in effect for one (1) year from the date executed unless revoked earlier by me. If revoked earlier, it is understood by all parties that the information released prior to being notified of such revocation was made at my request with my consent.

I have read the above and foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent.

Signature of Patient: _____ Date: _____

Authorized Representative:_____ Date: _____
(If signed by personal representative, state relationship/authority to do so)

Witness:_____