FOR OFFICE USE ONLY: NEW PATIENT FORM___ EXISTING PATIENT W/O FORM___

ADDITIONAL FORM___ REPLACEMENT FORM___

PATIENT NUMBER_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO ANOTHER PERSON (HIPAA)

Patient Name: _____ DOB: _____

I am authorizing **Gulf Coast Physician Partners** to release medical information about me to:

Emergency Contact--Name/Phone #	Relationship to patient
_____	_____
Name	Relationship to patient
_____	_____
Name	Relationship to patient
_____	_____

I hereby grant Gulf Coast Physician Partners approval to discuss my medical history as outlined below. Any exclusions will be noted. **This authorization will remain in effect until rescinded by me, in writing.** Gulf Coast Physician Partners may release this information to the above named, both in person and by phone.

NOTICE

This authorization is for **full disclosure** of pertinent records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, dates of clinic visits and hospitalizations. **If you do not want any information that may be related to drug, alcohol, psychiatric conditions and/or sexually transmitted diseases, including HIV/AIDS information released to the above persons, please indicate below what portions of your record you wish to be excluded. If none, please indicate with N/A**

EXCLUSIONS_____

These records are confidential and not for re-release by any facility other than Gulf Coast Physician Partners.

Patient Signature_____ Witness

Signature_____ Date_____

(PLEASE SIGN THIS FORM IN THE OFFICE, SO THAT WE MAY WITNESS)

GULF COAST PHYSICIAN PARTNERS
5907 BERRYHILL RD, MILTON, FL 32570
PHONE (850) 623-9787 FAX (850) 626-7512
DENNIS MAYEAUX, MD~JOSEPH FOUNTAIN, DO~
JANET LEWIS, MD~BACH-UYEN LE THI, MD

PLEASE RETURN A COPY OF THIS AUTHORIZATION WITH THE MEDICAL RECORDS

AUTHORIZATION FOR REQUEST OF MEDICAL RECORD

PATIENT NAME_____
DATE OF BIRTH _____ LAST 4 DIGITS OF SSN # _____
BEST PHONE NUMBER FOR CONTACT _____

I HEREBY AUTHORIZE GCPP TO OBTAIN RECORDS FROM:

DR (**first and last name**) _____
FACILITY_____
ADDRESS_____
_____
CITY _____ STATE_____ ZIP_____
PHONE # _____
FAX # _____

PLEASE SEND RECORDS TO:

GULF COAST PHYSICAIN PARTNERS
ATTN: SAMANTHA
5907 BERRYHILL RD
MILTON, FL 32570

PHONE-(850) 623-9787
FAX -(850) 626-7512

INFORMATION TO BE RELEASED (**PLEASE READ CAREFULLY AND MARK ONLY ONE OF THE BELOW CHOICES):**

__COMPLETE CHART FOR LAST YEAR SEEN IN THIS OFFICE
OR
__MOST RECENT OFFICE VISIT
__MOST RECENT LABS
__MOST RECENT X-RAY OR OTHER RADIOLOGY REPORTS
__MOST RECENT COLONOSCOPY/ENDOSCOPY/EGD
__ MOST RECENT ER / HOSPITAL VISIT

(GCPP HAS ACCESS TO ELECTRONIC MEDICAL RECORDS FROM AREA HOSPITALS)

PURPOSE OF DISCLOSURE:

__ NEW PRIMARY CARE DR.
__ CONTINUING CARE
__ LEGAL
__ WORKERS COMP.
__ INSURANCE
__ SCHOOL
__ CONSULTATION
__ SECOND OPINION
__ OTHER—PLEASE SPECIFY
_____

***REQUIRED (INITIAL AFTER READING):**
I understand my medical record may include, if applicable, specific laboratory test of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of AIDS or AIDS related conditions and other information regarding my treatment or hospitalization; including psychological or psychiatric impairment, drug abuse and / or alcoholism or sickle cell anemia.
I AGREE TO THE RELEASE OF SUCH INFORMATION _____

** I understand this authorization is valid for one year from the date of signature. I also understand that I may revoke this authorization at any time by notifying Gulf Coast Physician Partners in writing. It will be effective on the date of notification except to the extent that action has already been taken upon it.

Patient Signature _____ Date _____

Or Legal Guardian _____ Date _____