Rossana Moura, M.D., P.A.
Gastroenterology & Hepatology
1601 N. Palm Ave, Suite 311
Pembroke Pines, Fl. 33026
Telephone: (954) 874-7900 Fax: (954) 874-7901

Patient Authorization to Release Medical Information

Patient Name (Print) ____ Date of Birth: ____________________

I authorize ____ to use or release/disclose my health information as described below.

Please identify the information to be released:

☐ Please release my entire record -OR-

Please release *only* the following information:

☐ Most recent discharge summary
☐ Medication List
☐ Consultation Reports____
☐ Colonoscopy Reports ____
☐ Upper Endoscopy Report ____
☐ Pathology Results ____
☐ Lab Results ____
☐ X-ray and imaging reports ______________________________________
☐ Other: ____

The identified information will be used for the following purpose:

☐ My personal records
☐ Sharing with other health care providers as needed
☐ Other: ____

Please initial each item below to indicate your understanding.

____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual or organization:

Rossana Moura, M.D., P.A.
Palm Taft Professional Building
1601 N. Palm Ave, Suite 311
Pembroke Pines, FL 33026

This authorization will expire on: __________________________

If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

____ _____/_____/_____

Patient Signature (or Signature of Person Completing Form if Not Patient*) **Date**

*Relationship to patient: ☐Parent ☐Legal Guardian ☐Other: _____________________________

____ _____/_____/_____

Witness Signature **Date**