SURGICAL ASSOCIATES OF TAMPA BAY

205 S MOON AVE, SUITE 102,

BRANDON, FL 33511

**AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION**

Patient Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State,& Zip code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize that the protected health information regarding the above-named person be forwarded:

**From:** Person/Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_

**To:** **Surgical Associates of Tampa Bay**

205 South Moon Ave Suite 102, Brandon FL 33511

(813) 681-4644 TEL/ (813) 654-4486 FAX

**Dr.Narasimha, Dr.Thakkar, Dr.Chavda**

\_\_\_\_History & Physical \_\_\_\_Laboratory Report \_\_\_\_Operative Report \_\_\_\_Pathology Report

\_\_\_\_X-ray/Radiology \_\_\_\_EKG/EMG/EEG Report \_\_\_\_Consultation Report

\_\_\_\_Progress/Physician Notes \_\_\_\_Colonoscopy Report \_\_\_\_Discharge Summary

Records for the period (dates) from:\_\_\_\_\_\_\_\_\_ to:\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_