



Authorization for Release of Medical Records

PATIENT INFORMATION (Please Print):

Patient Name: _____ Date of Birth: _____
Social Security #: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip Code: _____

THE FOLLOWING IS AUTHORIZED TO RELEASE THE FOLLOWING:

Name: _____ Phone: _____
Address: _____ Fax: _____
City: _____ State: _____ Zip Code: _____

Forward to Health Information Management (Medical Records) for:

Operative Report Pathology Report History & Physical
 Laboratory Report Imaging Report Other: _____

THIS INFORMATION MAY BE RECEIVED BY:

Gastroenterology of Greater Orlando
2884 Wellness Ave.
Orange City, FL 32763
Office: (386) 668-2221 | Fax: (386) 668-2228

I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information that may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease, and all other sensitive information.

BY MY SIGNATURE, I AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO GASTROENTEROLOGY OF GREATER ORLANDO.

Patient Signature: _____ Date: _____

Authorized Representative: _____ Date: _____ (If Applicable)

2884 Wellness Avenue
Suite 100
Orange City, FL 32763
(386) 668-2221

929 N Spring Garden Avenue
Suite 150
DeLand, FL 32720
(386) 469-7993

835 Currency Circle
Suite 1001
Lake Mary, FL 32746
(407) 749-6656

8400 Red Bug Lake Road
Suite 2090
Oviedo, FL 32765
(407) 605-6511