Vishal Gupta, M.D.
Karl Mersich, M.D.
Kaleem Ahmed, M.D.
Dany Shamoun, M.D.
Jennifer Sinclair, M.D.
Arvind Gopal, M.D.
Rajiv Sharma, M.D.
Board certified in Gastroenterology

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 RECEIVE THE FOLLOWING:

Name: ____ Phone: ___________

Address: ____ Fax: ______________

City: _________________________________ State: _______ Zip Code: _____________

Forward to Health Information Management (Medical Records) for:

Operative Report   Pathology Report Laboratory   History & Physical

Laboratory Report   Imaging Report   Other: _____________

THIS INFORMATION MAY BE RELEASED FROM:
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 BY MY SIGNATURE, I AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO GASTROENTEROLOGY OF GREATER ORLANDO.

Patient Signature: ______________________________ Date: _____________

Authorized Representative: ______________________ Date: _____________ (If Applicable)