Gastroenterology of Greater Orlando

# 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)