

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)