5016 W. Cypress St.
Suite 200
Tampa, FL 33607
(813) 542-2589
www.Gastro-MD.com

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:

Gastro MD
5016 W. Cypress Street, Suite 200
Tampa, FL 33607
Office: (813) 542-2589 | Fax: (813) 392-1980

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 GASTRO MD.

Patient Signature: _____ Date: _____

Authorized Representative: _____ Date: _____ (If Applicable)