Vishal Gupta M.D.
Vernu Visvalingam M.D.
Karl Mersich M.D.
Kaleem Ahmed M.D.
Dany Shamoun M.D.
Jennifer Sinclair M.D.
Board Certified in Gastroenterology

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 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 RELEASED TO:

Gastroenterology of Greater Orlando P.A.
2884Wellness Avenue Suite 100
Orange City, Fl 32763
Phone: (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 P.A.

Patient Signature:_____ Date:_____

Authorized Representative:_____ Date:_____ (If Applicable)