



MEDICAL RECORDS RELEASE FORM

Patient Name: _____

Date of Birth: _____ Phone Number: _____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that, by initialing this form, I am specifically authorizing that release of this information.

Initials: _____

Date: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below:

DR.G PAIN & ORTHOPEDICS

Phone: (352) 251-2588

Fax: (352) 995-2015

info@drgpain.com

www.drgpain.com

LEESBURG CENTER: 8112 Centralia Ct. Suite 101, Leesburg, FL. 34788

THE VILLAGES: 1501 N. Hwy 441, BLDG 1600, The Villages, FL. 32159

I do give permission for these records to be faxed to the above entity. Please forward:

____Office Visits ____Initial History and Physical ____MRI Reports

____Lab Reports ____Correspondence ____Insurance Information

Other (please specify): _____

Patient Signature: _____ Date: _____