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: 8640 E CR 466 Suite A, The Villages, FL. 32612

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:________________