Tallahassee Gastro Health Center

Patient Authorization for Release of Medical Information

Patient's Name:
____

Date of Birth: _______________SS#: ________________________ Daytime Phone #: _______________________

I request & authorize _______________________________________ to release medical information of the above
(Name of Physician or Medical Practice)

named patient to: **Dr Kishor Muniyappa**
Tallahassee Gastro Health Center

I would like these records:
Faxed to **850-297-0352**

This authorization applies to the following information:
All medical records
Radiology
All Laboratory reports
EGD/Path report
Colon/Path report
Other:

Signature of Patient or Personal Representative: ____

Date: __________________

Printed Name of Patient or Personal Representative:

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Description of Personal Representative's Authority:

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