



DIGESTIVE HEALTH P H Y S I C I A N S

CONSULTATIVE GASTROENTEROLOGY ♦ GASTROINTESTINAL ENDOSCOPY ♦ HEPATOLOGY

REQUEST TO OBTAIN MEDICAL RECORD INFORMATION

To: _____ Address: _____

City, State: _____ Telephone: _____ FAX: _____

I hereby authorize the above facility to release medical records and/or information, including any HIV (AIDS) information to Digestive Health Physicians, PL (Drs. Dadrat, Herrera, O'Konski, Penuel, Yudelman and Richard Ornato) for:

Patient Name: _____ DHP Patient Number: _____

Date of Birth: _____ Social Security Number: _____

Direct Fax Information to: (239) 931-5060 Other _____

Please send the following information:

- Complete Record _____ Progress Record _____ Operative Record _____
- Discharge Summary _____ Consultation _____ EGD _____ Colon _____ Pathology Record _____
- History/Physical _____ Laboratory _____ Emergency Dept. _____
- Physicians' Orders _____ Radiology _____ Other _____ EKG _____

This authorization is for the listed date(s) of treatment:

From: _____ To: _____

Special instructions: _____

I further hereby release this provider from all legal responsibility and/or liability that may rise from the release of such records as specified above, and I hereby waive all rights I have to preserve their confidentiality.

Patient Signature: _____ **Date:** _____

If legal representative, sign below and state relationship and authority to do so and attach copy of the document of authority.

Legal Representative: _____

Authority: _____ Date of Signature: _____

(This request and information received are to remain in the patient's permanent medical record)

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7152 Coca Sabal Lane, Fort Myers, FL 33908
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(239) 947-2244 FAX: (239) 947-6358