AUTHORIZATION FOR RELEASE
OF CONFIDENTIAL INFORMATION

I, ____, hereby authorize
Print Patient Name

G & G Medical Group, Inc.
1132 Cypress Glen Circle
Kissimmee, Florida 34741
Tel: (407) 343-4700 Fax: (407) 343-8500

Permission to release and/or request:

______ Copy of the most recent Office notes, labs, ultrasounds and/or scans from the organization listed below.

______ Complete chart which includes all office notes, labs, diagnostic test, psychiatric drug/alcohol and AIDS information.

______ Speak/Write a letter to the person/organization listed below:

____
(Name of hospital, agency, or individual receiving information)

____
(Address, phone and/or fax number)

I understand that my records are protected under the Notice of Privacy Act. My records cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time by so informing the above name parties in writing: however such written revocation will have no effect on actions taken prior to the revocation. If I do not revoke this release, it will expire one year from the date of signature.

Patient's Signature: ____ Date: _________________

Date of Birth: _____________________

Address: ____

Apt\Unit#____________ City: ___________________________State: ____________

Phone:___________________ Cell\Other:__________________ Email: ______________________________