Gastroenterology Consultants
Of Central Florida, P.A.

Keith R. Moore, D.O
Board Certified
Gastroenterologist

Aniq Shaikh, M.D
Board Certified
Gastroenterologist

Authorization for Release Of Medical Records

Patient Name: _____

Address: _____

DOB: _____ SSN: _____ Phone: _____

Records needed by: _____ Mail Records: _____ Pick up Records: _____

Type of Records Requested: **ALL** _____or **Specific Records as indicated below**:

_____

_____

_____

_____

_____

_____

If Checked Include: ___**HIV related records** ___**Alcohol/Drug related Records** ___**Psychiatric Records**

I authorize Gastroenterology Consultants of Central Florida, P.A. to:

_____ Release Information to

_____ Obtain Information From

Name of Provider/Facility: _____

Address: _____

Phone: _____ Fax: _____

_____ _____

Signature of Patient or Representative Today's Date

10800 Dylan Loren Circle, STE 102
Orlando, FL 32825
Phone: (407)277-8665 **Fax:** (407)277-1267