Pediatric Gastroenterology of Central Florida

Dr. S. Bhargava

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize ____ to release

The **medical records of**____
(First) (Middle) (Last)

DOB: ___________________, to Pediatric Gastroenterology of Central Florida.

Records to include: ____

____

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____

I release you from all legal responsibility or liability that may arise from this authorization. This authorization includes consent to fax the above records.

Signed: __________________________

Date: _____________________________

Witness: __________________________

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