

MID-FLORIDA GASTROENTEROLOGY GROUP, P.A.

L.R. MALLAIAH, M.D., F.A.C.P.

DIPLOMATE OF THE AMERICAN BOARD OF
INTERNAL MEDICINE AND IN THE SUBSPECIALTY OF
GASTROENTEROLOGY

Authorization for Release of Medical Records

PATIENT INFORMATION:

NAME: _____ DOB: _____

SOCIAL SECURITY NUMBER: _____

PHONE NUMBER: _____

PLEASE RELEASE MY MEDICAL RECORDS (CIRCLE ONE) TO/FROM :

**(CIRCLE ONE) :TO/FROM: MID-FLORIDA GASTROENTEROLOGY GROUP
LENKALA R. MALLAIAH, M.D.
311 N. MANGOUSTINE AVENUE
SANFORD, FL 32771
PHONE: 407-321-4570**

PLEASE FAX RECORDS TO: **407-321-7690** THANK YOU ☺

**PLEASE RELEASE COPIES OF ALL MY MEDICAL RECORDS, INCLUDING
BUT NOT LIMITED TO, PROGRESS NOTES, OPERATIVE REPORTS,
LABORATORY RESULTS, AND DIAGNOSTIC TESTS.**

**BY MY SIGNATURE I AUTHORIZE THE RELEASE OF MEDICAL RECORDS
AS INDICATED ABOVE.**

Patient Signature: _____ Date: _____

Authorized Representative: _____ Date: _____