FRONTIER
GASTROENTEROLOGY & HEPATOLOGY

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Authorization for Release of Information

Date of visit: _____ First name: _____ Last: _____ MI: ___

SSN: _____-____-_____ Birth date: _____ Primary phone: _____

Home address: _____ Apt#: _____

City: _____ State: ____ Zip: _____

I hereby give permission to: _____

_____

_____

Phone: _____

Fax: _____

Please release a copy of my complete chart to: Frontier Gastroenterology and Hepatology
Dr. Mohamed Kaif
8109 State Road 54 Phone: (727) 232-2462
Trinity, FL 34655 Fax: (727) 807-6466

It is my understanding that by signing this authorization for release of records, I am giving permission for Frontier Gastroenterology and Hepatology to receive copies of any medical, psychiatric, HIV/AIDS, alcohol, and/or drug abuse related information for the above listed person. I hereby release the facility/physician/staff from any liability which may arise as a result of the use of information contained in the records released.

Patient signature: _____ Date: _____

Guardian name: _____ Signature: _____ Date: _____