

GASTROENTEROLOGY CONSULTANTS, PA

4700 Sheridan Street, Suite F
Hollywood, Florida 33021
(954) 961-8400
(954) 963-8508 fax

11011 Sheridan St., Suite 109
Cooper City, Florida 33026
(954) 431-7724
(954) 433-0218 fax

PATIENT REQUEST FOR RELEASE OF RECORDS

Patient Name: _____
(Please Print)

Date of Birth: _____

Doctor you are requesting records from: _____

Signed: _____ Date: _____

This form can be MAILED to the office checked above or FAXED to: (954) _____

RECORDS RELEASED
(To Be Signed on Receipt of Records)

I acknowledge receipt of my Medical Records from Gastroenterology Consultants, PA.

Signed: _____ Date: _____

Witness: _____ Date: _____

**PLEASE NOTE. WE WILL REQUIRE A MINIMUM OF FIVE WORKING DAYS TO
PROCESS YOUR REQUEST.**