COASTAL ORTHOPEDIC PAIN & SPINE CENTER

AMITABH GUPTA, MD SHRAVAN GUPTA, DO

PH 727-526-8000 FAX 727-521-2600

5800 49TH STREET N, SUITE S205
ST PETERSBURG, FL, 33709

7895 SEMINOLE BLVD, SUITE 101
SEMINOLE, FL 33772

I hereby authorize to release my medical records. I understand my records may include information relating to alcohol or drug abuse, communicable diseases, HIV testing and results, and psychiatric or psychological conditions.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM:

_____

PH# _____FAX # _____

RECORDS TO BE RELEASED: _____

PATIENT INFORMATION

Patient Name _____

Social Security# _____Date of Birth: _____

_____ **_____**

(Patient Signature) **(Date)**

_____ **_____**

(Witness Signature) **(Date)**

If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or discuss medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already provided to you. This consent and authorization expires in one year of the date signed.