PANAMA CITY GASTROENTEROLOGY

MACIEJ TUMIEL, M.D.

2101 NORTHSIDE DRIVE, SUITE 603

PANAMA CITY, FL 32405

(850) 784-8007 PHONE

(850) 784-1090 FAX

**AUTHORIZATION TO RELEASE MEDICAL RECORD**

I HEREBY AUTHORIZE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TO RELEASE THE INDICATED INFORMATION FROM THE MEDICAL RECORDS OF:

PATIENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INFORMATION TO BE RELEASED:

\_\_\_\_\_OPERATIVE NOTES \_\_\_\_\_LABS

\_\_\_\_\_HOSPITAL RECORDS \_\_\_\_\_XRAYS

\_\_\_\_\_HISTORY & PHYSICAL \_\_\_\_\_ALL RECORDS

RELEASE MEDICAL RECORD TO: MACIEJ TUMIEL, M.D.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I HEREBY CERTIFY THAT THIS AUTHORIZATION EXTENDS TO COVER RELEASE OF INFORMATION RELATED TO HIV TESTING, RESULTS OF TESTING, COUNSELING, AND/OR TREATMENT OF AIDS, AIDS RELATED COMPLEX (ARC), OR AIDS RELATED CONDITIONS. I FURTHER CERTIFY THAT THIS AUTHORIZATION EXTENDS TO COVER RELEASE OF INFORMATION RELATED TO PSYCHIATRIC AND/OR DRUG AND ALCOHOL ABUSE TREATMENT.

PATIENT SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_