Treasure Coast Gastroenterology

Scott Altschuler, MD

Records Request

I, the undersigned patient or legal representative, hereby authorizes Treasure Coast Gastroenterology to request any health information, including the diagnosis and records of any treatment or examination rendered to me.
PLEASE PRINT CLEARLY

Patient Name: _____ Date of Birth: _____

OFFICE USE ONLY: ***This information may be disclosed to and used by the following:***
Name: **Treasure Coast Gastroenterology Address:** 1701 SE Hillmoor Drive Suite 4, Port St. Lucie, Florida 34952
Phone Number: 772-777-2575 Fax Number:772-777-2875

The dates of service and the type(s) of information to be used or disclosed are as follows:
DATE(S) OF
SERVICE:_____
RECORDS REQUESTED:
_____
Hospital Name_____ **Facility**_____
DOCTOR('s) _____

This request is for the purpose of treatment, payment, and/or Health Care operations.
_____
This authorization will be valid while I am a current patient with Treasure Coast Gastroenterology. I understand that I may revoke this authorization at any time by notifying Treasure Coast Gastroenterology in writing, but if I do it will not have any effect on actions that Treasure Coast Gastroenterology took before it received the revocation.
I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
I understand that I may inspect or copy the information to be used or disclosed.

Signature of Patient or Legal Representative: _____
Date: _____
Address: _____
If signed by a Legal Representative, indicate your relationship to the patient below and provide appropriate documentation to verify your authority:
□ Parent □ Guardian □ Conservator □ Executor of Estate □ Power of Attorney □ Other