GIA GI ASSOCIATES OF TALLAHASSEE

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**Medical record transfer to another physician's office is a complimentary service. Medical records being reproduced for the patient or on behalf of the patient will be provided at the rate of $1 per page for the first 25 pages and then 25¢ for each page thereafter.**

I _____ on _____

hereby authorize the release of medical records for the purpose of :

_____ Medical Issues _____ Personal Issues

_____ Legal Issues _____ Insurance Issues

_____ Other: _____

for the treatment dates of: _____

From: Dr. Leonard Leichus and GI Associates of Tallahassee

To be sent to: Name: _____

Address: _____

City/State/Zip Code: _____

Phone #: _____

Fax #: _____

I authorize the release of records regarding any information concerning psychiatric treatment, drug and alcohol abuse treatment, immunodeficiency virus infections and AIDS. This will include any test results of tests and treatments, as well as any counseling records. I understand that my records are privileged and confidential in status. I am waiving the status for the purpose noted above. This authorization shall remain in force for 90 days for the purpose for which it was given.

I acknowledge that I have read this authorization and fully understand its contents.

_____ _____ _____

(Date of Birth) (Social Security Number) (Patient or Power of Attorney Signature)