MEDICAL RECORDS REQUEST

Charlotte Internal Medicine Associates

George Koppuzha MD
2400 Harbor Blvd # 19
Port Charlotte, FL 33952
P: 941.624.2787
F: 941.624.3047

Patient Name: ____________________________________ DOB: ______________

I authorize: (Provider) _______________________________ Phone: _______________

Medical Office: ___________________________________ Fax: _________________

Address: ____

____

-To release my personal health information to -

Provider: _______________________________________ Phone: ________________

Specialty: _______________________________________ Fax: __________________

For the purpose of: ____ Permanent transfer to new provider
____ Continuity of care with my primary
____ Consultation with a specialist: _______________________
____ Other: ____

Include records dating from _________________ to _________________

Specifically to include:

☐ CARDIOLOGY RESULTS	☐ COLONOSCOPY	☐ LAB REPORT
☐ COMPLETED RECORDS	☐ ENDOSCOPY	☐ RADIOLOGY
☐ HISTORY & PHYSICAL	☐ OFFICE NOTES	☐ EKG

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during the dates listed above. These may or may not include treatment of substance or other abuse, HIV, psychiatric disorders, sexually-transmitted diseases, etc., unless herein expected. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in six months from the date signed.

Signature of Patient: ___________________________________ Date: ______________