
JOSEPH J. KATTA M.D. P.A

GASTROENTEROLOGY

1900 NEBRASKA AVE STE #4 - #5, FORT PIERCE, FL 34950

PHONE: (772) 466-7200

FAX: (772) 466-0218

JOSEPH J. KATTA, M.D.

ROBERT S. EPSTEIN, M.D.

JESSICA SADLEY, MSN, APRN, AGACNP-BC

JACQUELINE NURSE, MSN, APRN, FNP-BC

VALERIA NIETO-GONZALEZ, MSN, APRN, FNP-BC

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION FROM OTHER HEALTHCARE FACILITIES

TO: _____

PHONE: _____ FAX: _____

I HEREBY AUTHORIZE YOU TO RELEASE MY INFORMATION INCLUDING DIAGNOSIS AND RECORDS OF
MY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD

FROM _____ TO _____.

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT SIGNATURE: _____ DATE: _____

WITNESS: _____

REQUESTING PROVIDER: KATTA / SADLEY / NIETO GONZALEZ / NURSE / EPSTEIN

PLEASE RETURN THIS FORM WITH RECORDS REQUESTED

OFFICE LOCATIONS:

<p>FORT PIERCE 1900 NEBRASKA AVE STE 4-5 FORT PIERCE, FL 34950 PHONE : (772) 466-7200 FAX : (772) 466-0218</p>	<p>ST LUCIE WEST 306 NW BETHANY DR PORT ST. LUCIE, FL 34952 PHONE: (772) 878-1475 FAX : (772) 878-1497</p>	<p>PORT ST LUCIE 1700 HILLMOOR DR SUITE 402 PORT ST. LUCIE, FL 34986 PHONE : (772) 236-5757 FAX : (772) 236-5758</p>
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