JOSEPH J. KATTA, M.D., P.A.

Gastroenterology

Fort Pierce - 1900 Nebraska Ave. • Suite 4-5 • Ft Pierce, FL 34950
St. Lucie West - 306 N.W. Bethany Drive • Port St Lucie FL 34986
Port St. Lucie - 1700 Hillmoor Drive • Suite 402 • Port St Lucie, FL 34952
Phone: 772-466-7200 Fax: 772-466-9513

Authorization to Release Medical Information Form

I hereby authorize,

- □ JOSEPH J. KATTA, M.D.
- □ JEAN HUBER, MSN, ARNP, FNP-BC
- □ MANUEL DOMAGTOY, MSN, ARNP, FNP-BC
- □ LISAMARIE SIMMONS, MSN, ARNP, FNP-BC
- □ ROBERT S. EPSTEIN, M.D.
- □ OLGA MEDINA, MSN, ARNP, FNP-BC
- □ BRENDA DOZACK, MSN, ARNP, FNP-BC

To release my medical records to include all Office Visits, Procedures/pathology, Radiology Reports, Laboratory Reports, and consult notes to:

Doctor/Facility/Company _____

Address: _____

Fax#: _____ **Phone#:** _____

Date of Service (FROM): _____ **(TO):** _____

Reasons for requesting medical records: _____
(e.g., continuing care, personal use, legal) _____

Patient Name: _____

Date of Birth: _____ **Social Security #:** _____

If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

_____ / _____
*Signature of Patient/Patient's Personal Representative*** *Printed Name*

_____ / _____/_____/_____
Relationship, if not Patient *Date Signed*