

# Elena Gurova, MD, PA

BOARD CERTIFIED INTERNAL MEDICINE

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I, \_\_\_\_\_, hereby authorize Elena Gurova, MD PA to disclose the following information by mail fax encrypted e-mail or orally to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone or Fax or Email: \_\_\_\_\_

**Patient's Name:** \_\_\_\_\_

**Patient's Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Medical Records Requested:

- Office visit notes
- Imaging Studies Reports (X-Rays, Ultrasound, CT, MRI, Mammogram, Bone Density, etc.)
- Cardiovascular reports (EKG, 2Decho, Stress Test, Spirometry, Vascular ultrasound, etc.)
- Consultations Reports (Cardiology, GI, Pulmonary, Neurology, etc.)
- Lab Reports
- Discharge Summary
- Other (must be specific)

This authorization is given freely for the purpose of \_\_\_\_\_ with the understanding that:

Any and all records are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. A photocopy of fax of this authorization is as valid as this original.

I may revoke this authorization at any time, except where information has already been released. To revoke my authorization, I must submit a Revocation of Authorization to Release Medical Information Form to the Elena Gurova, MD PA clinic. The clinic will act upon my revocation within two working days of receipt. This authorization is valid for a one year period from the date it is signed.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date