MEDICAL RECORD RELEASE

I hereby request that my:

_________Medical Records

_________ X-Rays

_________Other (specify)__________

Be released to:

____

Physicians Name (print)

____

Address

____

City __________________ State ______ Zip___________

Phone :________________ Fax : _______________________

Patient's Name:____

SSN:______________________ or DOB:______________________

Patient's Signature: ____

Date:_____________________

6800 N. Dale Mabry Hwy., Suite 242, Tampa, FL 33614 • (813) 884-1314 • Fax (813) 884-1315
10221 Yale Avenue, Brooksville, FL 34613 • (352) 596-0900 • Fax (352) 596-0440
7544 Jacque Road, Hudson, FL 34667 • (727) 697-2200 • Fax (727) 863-8774
5319 Grand Boulevard, New Port Richey, FL 34652 • (727) 848-1769 • Fax (727) 848-4489