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The Next Generation in Healthcare

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ DOB: _____

I hereby request and authorize you, your employees and agents to furnish all records and reports, including x-rays and photostatic copies and any other information relating to any examination, treatment or opinion concerning any condition that I may have had in the past or now have.

Other: _____

_____

Fax Records to: 954-888-6645

_____ _____

Signature of Patient/Responsible Party **Today's Date**

Fax To:_____

Fax Number:_____

Telephone Number:_____