PATIENT RECORD RELEASE

Date_____ Patient _____
LAST M.I. FIRST

Address _____

City _____ State _____ Zip _____

☐ This patient is being transferred to you for care. If further information is required please contact our office.

☐ This patient has come to our office for care. Please supply necessary information and/or a copy of the patient's record for our use.

To: _____	From: _____
Address _____	Address 1128 BICHARA BLVD
City _____	City LADY LAKE
State _____ Zip _____	State FL Zip 32159
Phone # _____	Phone # (352) 750 - 2414
Fax # _____	Fax # (352) 259 - 4285

Notes _____

_____

I hereby grant permission for the above named persons to exchange information from my case records.

_____ ☐ Parent
PATIENT'S SIGNATURE

_____ ☐ Guardian
DATE