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 1320 SHELFER ST

City _____ City LEESBURG

State _____ Zip _____ State FL Zip 34748

Phone # _____ Phone # (352) 728 - 8318

Fax # _____ Fax # (352) 728 - 0057

Notes _____

_____

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

_____ ☐ Parent
PATIENT'S SIGNATURE

_____ ☐ Guardian
DATE