MID-FLORIDA CARDIOLOGY SPECIALISTS

DATE: ________________________________
DR/HOSPITAL __________________________
PHONE ________________________________
FAX __________________________________
ATTN _________________________________

PLEASE FAX STAT

MID-FLORIDA CARDIOLOGY SPECIALISTS
HEALTH CENTRAL: 1000 W. COLONIAL DR., SUITE 282, OCOEE, FL 347621
DOWNTOWN: 1717 SOUTH ORANGE AVE., SUITE 105, ORLANDO, FL 32806
PHONE: (407) 351-5384 FAX: HEALTH CENTRAL (407) 445-3515
FAX: DOWNTOWN (407) 843-3571

RECORD RELEASE **DATE:** __________________________

TO ____

I HEREBY AURTHORIZE YOU TO RELEASE TO:

MID-FLORIDA CARDIOLOGY SPECIALISTS / SELF __________________

ANY INFORMATION INCLUDING MECIAL, PSYCHIATRIC, ALCOHOL, AND/OR DRUG ABUSE, HIV TESTING, ARC AND/OR AIDS DIAGNOSES AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD FROM:

___________________ **TO** _________________ **TO INCLUDE** ________________________________

ALL RECORDS ____

_________________________________ _____________________________________
PRINT PATIENT NAME **SIGNATURE**

_________________________________ _____________________________________
DATE OF BIRTH **ADDRESS**

_________________________________ _____________________________________
SOCIAL SECURITY NUMBER **WITNESS**

MID-FL RECORD # _______________ **MID-FL DOCTOR #** __________________

THIS REQUEST IS __________**URGENT** _______________**ROUTINE**

PLEASE MAIL TO THE ABOVE ADDRESS OR FAX RECORDS.