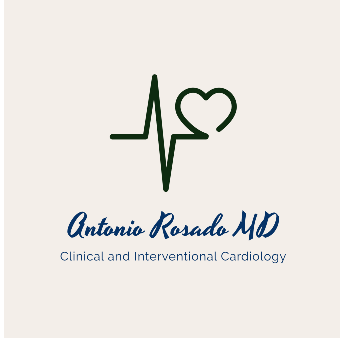

Authorization To Release Medical Records

Patient's Name:____________________________Date of Birth: _______________________

Address: ____

City:_______________________ State: __________ Zip/Postal ode:_________

Telephone:__________________ Email: __________________

Date of Birth: _______________________________ Social Security Number: _____________

I authorize ____
to release of my medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information noted below:

____

concerning my health and treatment during the period of __________ to __________; to be sent to the following doctor's office:

Antonio Rosado, MD
Address: 4302 Alton Road,
Suite 470
Miami Beach, Fl. 33140

Please Fax records to 305 397-8889

Office Telephone: (786) 709-5865   Email: frontdeskin470@gmail.com

Patient's Signature: ________________________________ Date: _________________________

This authorization is valid until: ___________ . date