South Florida Breast Specialists

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Medical Records Request

Authorization for Use, Disclosure, and Release of Health Information

Date: ___________________________

Patient: ____ DOB:____________________

The above named patient requests and authorizes the release of their medical records TO or FROM:

____
(Full Name of Physician or Facility)

____

(Phone) (Fax)

Please Include:

____ Office Notes ____ Pathology/OP Reports

____ Lab Results ____ All Records

____ Diagnostic Results

_____________________________________ ____________________________

Patient Signature (or Legal Representative) (Date)