ELIAS A. FEANNY, M.D., P.A.
CORAL REEF MEDICAL BUILDING PARK 2
9275 SW 152ND STREET #101 MIAMI, FL. 33157
PHONE (305)2538869 FAX (305)2339726

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: ______________________

To: ____

Phone: ____________________________ *Fax:* ____________________________

I hereby authorize you to release records to:

ELIAS A. FEANNY, M.D., P.A.
CORAL REEF MEDICAL BUILDING PARK 2
9275 SW 152ND STREET #101 MIAMI, FL. 33157
PHONE (305)2538869 FAX (305)2339726

Copies of my medical records in you possession, concerning my illness and / or my treatment, as indicated below:

____

Dates of Service: ____

Please indicate if the records (MAY INCLUDE) the following:

YES ____ NO ____ Psychiatric or mental health illness
YES ____ NO ____ Drug and alcohol abuse records
YES ____ NO ____ HIV, AIDS Test/Diagnosis, or related conditions
YES ____ NO ____ (Women) Abortion records

I release Dr. Elias A. Feanny M.D., P.A. of all responsibility for loss of confidentiality access and / or copies of records released in compliance with this authorization.

Patient Name: ____

Address: ____

Date of Birth: ____________________________ ***SS#***____________________________

Patient Signature: __________________________ ***Date:*** ____________________________

Witness Signature: __________________________ ***Date:*** ____________________________