



## Records Release Authorization

I hereby authorize and request you to release my complete medical record in your possession concerning my illness and/or treatment during the period from \_\_\_\_\_ to \_\_\_\_\_.

### TO BE RELEASED FROM:

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### SENT TO:

6850 International Center Blvd  
Fort Myers, FL 33912  
Phone: 239-768-0006  
Fax: 239-768-0850

1109 Del Prado Blvd S  
Suite 10  
Cape Coral, FL 33990  
Phone: 239-574-5406  
Fax: 239-574-9212

11176 Tamiami Trail N  
Naples, FL 34110  
Phone: 239-594-0124  
Fax: 239-594-1040

**PATIENT NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

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**DATE OF BIRTH:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_