Release of Medical Records

Facility/Doctor: ____

Patient Name:____

SSN:__________________________ **D.O.B:** ____/____/____

I hereby grant permission to disclose and/or release all information and records regarding my treatment, diagnostic reports, X-ray reports, and consulting reports.

Please fax these reports to:

Dr. Lisa Marsh

727.772.0096

Please call if you are unable to fax the requested reports:

727.772.1966

Patient Signature: ____

Date: _________________________