6200 Sunset Drive, Suite #401
South Miami, Florida 33143

Diplomates,
American Board of Cardiovascular Disease
American Board of Internal Medicine

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MEDICAL RECORDS RELEASE

Date : ....

To: .... From: ....
Physician/Hospital

Phone: .... Fax: ....

I hereby authorize and request you to release my Medical Records/Testing results to:

6200 SUNSET DRIVE, SUITE #401
SOUTH MIAMI, FL 33143

Patient Name: .... DOB: ....

SS#: ....

Witness if unable to sign: ....

Relationship to patient: ....

Signature: ....