MEDICAL RECORDS RELEASE FORM

To: _____

Doctors Office or Hospital

Address: _____

I hereby authorize the release of my Medical Records To: _____

Privamedis Concierge Medicine
4308 Alton Road
Suite 880
Miami Beach, Fl 33140

Phone: 305-604-2888
Fax: 305-604-2887

Please release the complete medical record in your possession concerning any medical treatment during the period of_____ to _____.

Patient Name: _____

Address: _____

D.O.B. _____ Social Security:_____

Signature:_____ Date:_____