RECORD RELEASE AUTHORIZATION

TO:_____

(Doctor's Name)

_____

(Address, Phone #)

I hereby authorize and request you to release to:

Adriana M Castro MC

9220 SW 72nd ST

Suite 102

Miami, FL. 33173

Phone: (305)275-1700

Fax: (305)275-5008

The complete history and records in your possession concerning my treatment during

The period from_____to_____

Name:_____

Address_____

Phone_____

Signature_____

Witness_____