**Zoyla Almeida M.D. P.A.**
**4855 W Hillsboro Blvd., Suite B-13**
**Coconut Creek, Fl. 33073**
**954-420-9182 Fax 954-420-9184**

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

PATIENT INFORMATION:

Patient Name: _____

Address: _____

City, state, Zip Code: _____

Phone Number: _____

**RECORDS RELEASED TO:**

Physician Name or Practice: _____

Address: _____

City, State, Zip Code: _____

Phone/Fax Number: _____

**RELEASED FROM: Zoyla Almeida M.D. P.A. 4855 W Hillsboro Blvd. Suite B13**
**Coconut Creek, m. 33073**
**Tel: (954) 420-9182 Fax: 954-420-9184**

I hereby release Dr. Almeida and its employees from any and all liability that may arise from the release of information as I have directed.

_____ _____

Signature of Patient or Legal Guardian Date