MIAMI OB · GYN, LLC

Physicians Dedicated to Quality Healthcare for Women

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Patient Release of Medical Records Form

Patient Name: ____

Date of Birth: ____________________ Social Security #: ____________________

I hereby authorize to release copies of my medical records to the physician noted bellow:

To New Physician:

Physician's Name:____________________

Address:____________________

____

Phone:____________________

Fax:____________________

From Previous Physician:

Physician's Name:____________________

Address:____________________

____

Phone: ____________________

Fax: ____________________

Please mark the reason which best describes why you have requested your medical records:

- ☐ I am seeking a second opinion
- ☐ I am moving out of town
- ☐ I am switching physicians because ____________________
- ☐ Other reason: ____________________

____________________ ____________________

Patient / Legal Guardian Signature Date

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