RECORDS RELEASE AUTHORITY

TO: _____

I, _____
Patient's Name

hereby request that you release all my records to:

Women's Healthcare of Kendall, LLC
10700 North Kendall Drive, Suite 200
Miami, FL 33176
TEL 305.270.7999 FAX: 305.270.6788
Suzette Delgado, MD, FACOG
Mary A. Leyva, CNM
Pauline R. Theobalds, CNM
Lauren D. Viego, APRN

Reports of my diagnosis, treatments, prognosis, and recommendation, as well as other data pertinent to your treatment of me from _____ to _____.

_____
Date of Request

_____
Patient's Signature

_____
Date of Birth

_____
Address

_____
City, State, Zip Code