Sample Medical Center
5596 W Sample Rd Margate, FL 33073
Office 954-968-4000 Fax 954-968-4099

Authorization for Release of Medical Records and Information

Patient Name : _____ **DOB:** _____

I authorize : _____

To release a copy of (List specific information/documents)

_____

_____

_____

_____

To: _____

Address: _____

City:_____, **State:**_____ **Zip**_____

INFORMAITON TO BE RELEASED (Please circle Yes or No for each category listed)

Y-N Medical History Y-N Operation Reports Y-N Mental Health Records

Signature:_____ Date:_____

Witness:_____ Date;_____