CARLOS R. SANTOS M.D. PA

PATIENT'S REQUEST AND AUTHORIZATION FOR,

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TO PROVIDE A COPY OF THE SPECIFIC HEALTH AND MEDICAL INFORMATION AS DESCRIBED BELLOW:

PATIENT NAME: _____

Select only one of the following:

[ ] All health information pertaining to any medical history, mental or physical condition and treatment received: _____
_____

[ ] Only the following records or types of health information (Including any dates):
_____
_____

The designated information should be sent to:
_____

NAME: _____

ADDRESS: _____

DATE: _____

SIGNATURE: _____

PHONE: _____ **FAX :** _____