# CARLOS R. SANTOS M.D. PA

MEDICAL RECORDS RELEASE AUTHORIZATION

PATIENT NAME: _____

I HEREBY REQUEST AND AUTHORIZE YOU TO RELEASE MY MEDICAL RECORDS TO:

Carlos R. Santos MD, PA
909 North Miami Beach Blvd, Suite 402
North Miami Beach, FL 33162
Ph: (305) 653-0425
Fax: (305) 653-4055

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: _____

PHONE: _____ DATE: _____

DATE OF EXPIRATION: _____

SIGNATURE: _____