MEDICAL RECORDS RELEASE FORM

Date:_____

PATIENT NAME_____

DATE OR BIRTH_____

ADDRESS_____

_____

SOCIAL SECURITY #_____

Authorization

I,_____,hereby

give authorization to release my medical records to the below entity

Dr. Jose Marquina, MD

1855 Veterans Park Dr.

Suite # 302

Naples, FL 34109

Phone: 239-592-5864

Fax: 239-592-6214

SIGNATURE OF PATIENT (OR LEGAL GUARDIAN)

_____

WITNESS_____