Phone: 772-402-3449 **Fax**: 772-310-3811
Web: www.heartandrhythm.us

MEDICAL RELEASE FORM

Patient Name ____Date of Birth ____/______/______

SSN______________________________Address___________________________City________________

State_____ Zip Code _______________Phone________________Email____________________________

INFORMATION REQUESTED FROM

Name ____
Address ________________________________City ____________________State ____Zip Code ______

Phone _____________________Fax________________________ Email_____________________________

SEND INFORMATION TO

Name_______________________________________Send by ☐ Mail ☐ Fax ☐ Secure Email
Address ________________________________City ____________________State ____Zip Code ______

Phone _____________________Fax ________________________ Email____________________________

I________________________________(Name), herby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information, to the physician/ person/ facility/ entity.

____ ________________________
Printed Name Date

____ ________________________
Signature Date