Florida Cardiopulmonary Center
Central Florida Pulmonary Consultants

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RECORDS RELEASE REQUEST

To:

_____ _____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____ _____

I, _____, hereby request that you release my MEDICAL RECORDS to:

CENTRAL FLORIDA PULMONARY CONSULTANTS, P.L
759 Harley Strickland Blvd
Orange City, FL 32763
Phone: (386) 456-0300
Fax: (386) 456 -0303

This includes a report of my diagnosis, treatment, prognosis and recommendations, as well as any other data pertinent to your treatment of me. I request ALL of my records to be sent unless specific dates or specific tests are listed below. Thank you.

- Release records only for the following period.

FROM: _____/_____/_____ TO: _____/_____/_____

- Release records only for the following test(s) / report(s):
(Please Include Dates)

_____
_____
_____

REASON FOR REQUEST:

☐ Continuity of CareTreatment ☐ At the Request of IndividualPlease Include All Sensitive Information

_____ _____
Date of Request Date of Birth

_____ _____
Social Security Number Patient's Telephone Number

_____
Patient Printed Name

I understand and give my permission for my records to be sent via facsimile (fax machine).

_____
Patients Signature

Faxed:_____/_____/_____