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
915 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 Care Treatment

☐ At the Request of Individual Please 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:_____/_____/_____