6 South 14th Street
Fernandina Beach, FL 32034
904.261.5741 Office
904.261.7383 FAX

Release of Medical Records

TO: ________________________ Date:___________________

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I hereby request that my records, including diagnosis, treatment, prognosis, recommendations, and office notes to be released to the above named individual.

Thank you for your assistance.

Patient Name: _______________________ DOB: ____________________

Patient Signature: ____