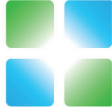

THE MEDICAL GROUP
OF SOUTH FLORIDA, INC.

MEDICAL RECORDS RELEASE AUTHORIZATION

NOTE: YOUR SIGNATURE ACKNOWLEDGES THAT YOU UNDERSTAND THIS AGREEMENT	
Patient Name	Patient's Date of Birth / /
Address	
Doctor/Hospital	
I hereby authorize the release of my Medical Records to be sent to the any of these locations, Medical Group of South Florida	
☐ 1094 Military Trail, Jupiter, FL 33458	Fax 855.215.9930
☐ 4700 N. Congress Suite # 103, West Palm Beach, FL 33407	Fax 855.346.3451
Patient Signature	Date / /
Print Name	
Guardian Signature	Date / /
Witness to Above Signature (print name)	