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)	