

RECORDS RELEASE

Date: _____

TO: _____
Doctor or Hospital

Address, City, State, Zip Code

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE



Women's Care
Florida

Clinical Research

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3268 Cove Bend Drive, Tampa FL 33613
(813) 739-1174

THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESS
AND/OR TREATMENT DURING THE PERIOD FROM _____ To _____.

SIGNED: _____
(Patient)

RELATIONSHIP: _____