LINDA MARRACCINI, M.D & JOHN MARRACCINI
6280 SUNSET DRIVE SUITE #407
MIAMI, FL 33143
PHONE # 305-666-8858
FAX # 305-665-1731

AUTHORIZATION REQUEST FOR RELEASE OF MEDICAL RECORDS

DATE _____

STAT PATIENT IN OFFICE!

PATIENT NAME _____

SS# _____ DOB: _____

I HEREBY AUTHORIZE: (NAME & FAX NUMBER)

_____
_____
_____
_____

TO RELEASE MY MEDICAL RECORDS TO: DR. LINDA & JOHN MARRACCINI.

I REQUEST ALL MY MEDICAL RECORDS THAT MAY HAVE BEEN ACQUIRED BY EXAMINATION OR ANY OTHER MEANS, REGARDING MY PHYSICAL OR MENTAL CONDITION. I HEREBY RELEASE THE PHYSICIAN OF ANY CONSEQUENCE PURSUANT TO THIS RELEASE OF RECORDS.

_____
PATIENT NAME (PRINT)

PLEASE FAX RECENT
NOTES, LABS, EKS & IMAGES
THANKS!

_____
PATIENT SIGNATURE

_____
WITNESS

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