Release of Information

I HEREBY GIVE PERMISSION TO:

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TO RELEASE A COPY OF MY MEDICAL RECORDS

TO: H.F. MEDICAL ASSOCIATES, P.A – Henriete D. Faillace, M.D.
2627 NE 203rd Street, suite 101, Aventura, FL – 33180
Phone: (305) 935-2452 Fax: (305) 937-2622

NAME OF PATIENT: ______________________________

SIGNATURE OF PATIENT: __________________________

SIGNATURE OF GUARDIAN: _________________________

SIGNATURE OF WITNESS: __________________________

DATE: ______________ *DATE OF BIRTH:* ____________