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**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
FROM CENTRAL FLORIDA CARDIOLOGY GROUP, P.A.**

I, _____ authorize Central Florida Cardiology
Group, P.A. to furnish a copy of my medical records covering the period from

_____ to _____

PHYSICIAN'S NAME

ADDRESS

CITY, STATE, ZIP CODE

PHONE

FAX

This authorization includes consent to fax the above records if necessary. Yes No
I release you from all legal responsibility or liability that may arise from this
authorization.

PATIENT NAME

SIGNATURE

D.O.B.

SS #

WITNESS

DATE

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