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

I, \_\_\_\_\_ authorize, \_\_\_\_\_
Patient Name ( Please Print) Hospital, Individual, Agency or Physician

a copy of my medical records covering the period from \_\_\_\_\_ to \_\_\_\_\_

to Dr. \_\_\_\_\_ at:

CENTRAL FLORIDA CARDIOLOGY GROUP, P.A.
1745 NORTH MILLS AVENUE
ORLANDO, FL 32803
PHONE: 407-841-7151

FAX NUMBERS: 407-872-1336 – Nurse’s Station
407-425-2768 – Medical Records
407-841-8572 – New Patient Coordinator
407-481-1032 – 1st Floor Reception
407-581-0439 – 1st Floor Nurse Station
407-365-7593 – Oviedo Office

I release you from all legal responsibility or liability that may arise from this authorization.

Form with fields for PATIENT NAME, SIGNATURE, D.O.B., SS #, WITNESS, and DATE.

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