



3614 West Kennedy Blvd. Suite B
Tampa, FL 33609
Tel (813) 870-2528 fax (813) 876-1003

I _____ authorize you to release my medical records and information to:

South Tampa Medical Group
Dr. _____

3614 W. Kennedy Blvd. Suite B
Tampa, FL 33609
(813) 870-2528

I understand that this doesn't include any hospital reports or reports from other doctor's offices. I understand that other doctor reports and medical information must be obtained by me. From the office where services were rendered.

Print Patient Name

Patient Signature

Social Security Number

Date of Birth