Date: ___________________

I, ____, hereby authorize Advanced Hand and Plastic Surgery Center, LLC, to release my medical records to

Attn.:____

Fax no.: ____

Address:____

City/State/Zip:____

Please release RECORDS via:
(Please circle one) Fax or Mail

Signed:____

Witness:____

Thank you
Emilee Cabatana, Medical Records
813-712-3149