
# MEDICAL RECORDS RELEASE FORM

## Patient:

| |
|---|
| Name: |
| Address: |
| City, State, Zip: |
| Phone: |
| DOB: |

## Releasing Physician / Hospital:

| |
|---|
| |
| Address: |
| City, State, Zip |
| Phone # |

## I authorize release of my medical records to:

| |
|---|
| Dr. Sears' Center for Health and Wellness |
| 11905 Southern Blvd. |
| Royal Palm Beach, FL 33411 |
| **Tel:** 561-784-7852 **Fax:** 561-784-7851 |

Patient Signature _____

Date_____