

# RECORDS RELEASE AUTHORITY

Date \_\_\_\_\_

To: \_\_\_\_\_

*DOCTOR/HOSPITAL*

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

I hereby authorize the release of my \_\_\_\_\_ or copie  
of such and request that they be transferred to:

**DOCTORS INN  
ROBERT P. FEDOR, D.O., P.A.  
13495 GULF BLVD.  
MADEIRA BEACH, FL 33708  
(727) 391-4100**

\_\_\_\_\_  
*Print name of patient*

\_\_\_\_\_  
*Signature (patient, parent or guardian)*