Dr. Peter A. Thomas
& ASSOCIATES

Medical Records Release Form

Patient's Name ____

Date of birth ____/____/____ Telephone number (____) ____-____________

Address ____

____

Please release my medical records to:

Dr. Peter A. Thomas & Associates, LLC
4700 S Flamingo RD, Cooper City, FL 33330
Ph: (954) 252-9191 Fax: (954) 204-3731

From:

Name of provider ____

Provider's number ____

Provider's address ____

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

Signature: ____ Date: ____________