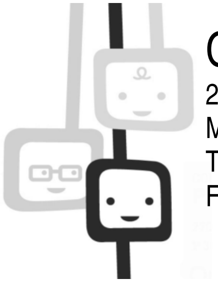

Cordero, Perez-Silva & Rodriguez, MD PA
2700 SW 3 Avenue, Suite 1-F
Miami, Florida 33129
Tel: (305) 285-2574
Fax: (305) 285-5505

Release of Information

I, ________________________________ , being the patient (parent or legal guardian of the patient), do hereby request Cordero, Perez-Silva & Rodriguez, PA to release medical records specified below to:

____
Physician Practice

____
Address

____
City, State & Zip   Phone Number

Please check your selection:

______ All records relating to (please specify) ________________________________

______ Entire patient record.

Reason for release of information:

____

____

This authorization is valid up to one (1) year after my signature appears on this form and authorizes release of patient records up to and including the date of this release. I may revoke this authorization at any time except to the extent that the records have already been released. Any re-disclosure of this information, depending on the nature of the information, may not be permitted without my specific authorization.

____   _________________
Print Patient Name   DOB

____   _________________
Signature of Patient, Parent, or Guardian   Date