RECORDS RELEASE AUTHORIZATION

TO:

_____

_____

_____

I HEREBY AUTHORIZE YOU TO RELEASE THE COMPLETE HISTORY AND MEDICAL RECORDS TO:

Donna Sperber MD
5033 Central Avenue
St Petersburg] FL 33710
Tel: 727-623-4830
Fax: 949-863-5381

PATIENT NAME: _____

DOB _____

ADDRESS: _____

_____

SIGNATURE: _____

PRINTED NAME: _____

DATE: _____