COLIN CHAN, M.D. & ASSOCIATES

Authorization to Release Medical Records

Patient Name: _____

Date of Birth: _____

Release of Records From: _____
Physician Name

_____
Address

_____
City, State, Zip Code

_____
Phone Number **Fax Number**

Information to be released: ____ Entire Medical Record _____ X-ray's _____ Labs

Other_____

Please fax/mail records to: **Colin Chan, M.D.**
12450 Roosevelt Blvd N, Ste 101
St Petersburg, FL 33716
PH# 727-571-1688 Fax# 727-561-0674

I authorize my records to be released to the above mentioned physician. I understand I have the right to revoke this request at any time. This request will expire one year from the date of signature.

Patient Signature Date