TRANSFER OF MEDICAL RECORDS

I (Patient's Name) _________ ____ a resident of
(Patient's Address) ____
with date of birth _____________________________
and Social Security Number OR Driver's License Number_______________________________
authorize, ____ (Name of Physician/Practice)
with office location____
Phone # _____________________________ Fax # ________________________________
to release my patient health record / summary to :

Dr. Jonathan Alvior (ALVIOR MEDICAL CLINIC)
1905 West Busch Boulevard Tampa, Florida 33612
Phone: 813-365-3525
Fax: 813-365-3515

I understand that this authorization is valid only for 90 Days.

Patient Signature: ______________________ Date: _______________________________