MARLENNY FELIZ CRUZ , MD; PA

18503 Pines Blvd. Suite 311
Pembroke Pines, Florida 33029
Office (954) 885-6565

Request for Release of Medical Records

To:____

____

Office Phone: ______________________________ Office Fax:_____________________

In order for us to fully evaluate this patient's health and make an informed decision, the patient has approved our request for copies of all relevant medical records in your office.

I hereby authorize release of my complete medical history to Dr. Marlenny Feliz Cruz. These records are to include psychiatric, substance abuse, and HIV testing/AIDS related complex information.

Please complete all sections below:

Date of Birth: / / Today's Date: / /

____
Patient's Name (Printed)

_____________________________ _________________________
Patient's Signature Witness

Please Fax Records to 1-888-727-7735