Authorization for Medical Records Release

Patient Name:____Date of Birth:_____/_____/_____

To disclose/release the following information *(check all applicable):

☐ All records ☐ Office notes ☐ Laboratory/Pathology records

☐ Radiology records ☐ Other _______________

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I authorize the release of the medical records selected above to:

☐ Dr. Michael C. Solomon

555 NW Lake Whitney Pl. Suite 103
Port St. Lucie, FL 34986
Phone: 772-468-0042
Fax: 772-468-0309

________________________	________________
Patient's Signature	Date
________________________	________________
Office Staff	Date
________________________	________________
Power of Attorney (If applicable)	Date