ROIS MEDICAL GROUP
HEALTH & WELLNESS

Medical Records Release Authorization

Attention to Dr. _____ Phone / Fax _____

I hereby authorize and request you to release copy of:

- ☐ Medical Records
- ☐ Labs
- ☐ Diagnostic Imaging

To: Dr. Ricardo Rois

Rois Medical Group

903 Jordan Blass Drive, Suite 103, Melbourne, FL

T: 321.421.7122 Fax Number: 866.611.2535

Patient Name: _____ DOB: _____

Patient Signature: _____

Date Requested: _____Requested by _____

Ricardo Rois Romero, MD