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

5462 Village Dr. Rockledge, FL / T: 321.421.7122 Fax Number: 866.611.2535

Patient Name: _____ DOB: _____

Patient Signature: _____

Date Requested: _____Requested by :_____

Ricardo Rois Romero, MD