EMERGENCY
PHYSICIANS MEDICAL CENTER

Medical Records Release Form

Patient's name: _____

Date of birth: _____

Address: _____

_____

Telephone number: (_____) _____

☐ **Please release my medical records from:** ☐ **Please release my medical records to:**

Emergency Physicians Medical Center
2445 SW 76th Street, Suite 110
Gainesville, FL 32608

TO:
Name of Provider: _____

Provider Address: _____

_____

Please include the following: _____

_____ _____

Patient/Guardian Signature Date