# Records Release

**Date:**_____

**To:** _____

_____

_____

**I hereby authorize you to release my medical records to:**

**CFP Physicians Group, P.A.**
**985 S.R. 436**
**Casselberry, FL 32707**
**Phone: (407) 831-5252 Fax: (407) 831-3765**

**Time period requested:** _____ **through** _____
(Date) (Date)

**These records are to include any psychiatric testing, any testing for the HIV antibody and any testing for substance abuse. If you wish to exclude any from record, please specify:** _____

This authorization is valid until expiration on _____ or a maximum of two years from this dated release.

**X**_____
(Signature)

**X**_____ _____
(Witness Signature) (Please Print Name)

_____ _____
(Print Name) (Relationship to the Patient)

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**Patient's Name**_____ **Patient's Date of Birth**_____

**Patient's SSN:** _____-_____-_____