RECORDS RELEASE AUTHORITY

Date _____

To: _____
DOCTOR/HOSPITAL

Address: _____

City: _____ State: _____ ZIP: _____

I hereby authorize the release of my _____ or copie
of such and request that they be transferred to:

DOCTORS INN
ROBERT P. FEDOR, D.O., P.A.
13495 GULF BLVD.
MADEIRA BEACH, FL 33708
(727) 391-4100

_____ _____
Print name of patient *Signature (patient, parent or guardian)*

FM-