RECORDS TRANSFER REQUEST

Date:_____

To:_____
(Doctor/Hospital)

Address:_____

City:_____ State:_____ Zip:_____

I hereby authorize the release of my medical records or copies of such, including psychiatric and infectious diseases, and request that they be transferred to :

Lynne M. Ellis, M.D., P.A.
1111 7th. Avenue North, Suite 103
St. Petersburg, FL 33705
Phone (727) 822-5393
Fax (727) 895-3313

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

_____ _____
Address Phone

_____ _____
Date of birth Social Security #