

Orthopaedic Specialties of Tampa Bay, P.A.
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Clearwater, Florida 33756
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TO:

FROM:

FAX NO:

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Message: Urgent Reply ASAP Please Comment Please Review

REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____

ADDRESS: _____

PHONE: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NO: _____

I hereby request that my medical records be released to:

DR. _____

Orthopaedic Specialties of Tampa Bay, P.A.
1011 Jeffords Street, Suite C
Clearwater, Florida 33756

SPECIAL REQUEST: _____

SIGNATURE _____

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