RECORDS REQUEST

KNOW ALL MEN BY THESE PRESENTS: THAT I, _____ HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL RECORDS TO BE SENT TO:

SELECT HEALTH AND WELLNESS
1845 EAST WEST PARKWAY, SUITE 10
FLEMING ISLAND, FL 32003
PHONE: 904.425.9060
FAX: 904.425.9061

A FAXED COPY OF THIS RELEASE IS TO BE CONSIDERED AN ORIGINAL

_____

PATIENT

_____

WITNESS

_____

DATE