TRINITY RELEAF

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: ____ **DOB**: ____/ ____/ _____

Previous Name: ___________________________ **Social Security Number**: _______-_______-_______

I request and authorize the following offices/ physicians/ hospitals

Name of facility/Doctor: ____

Phone number: _________________________________ Fax number: _________________________

to release health information of the patient named above to:

Robert J. Ferreira, M.D. **Leo Vieira, M.D.**

2044 Trinity Oaks Blvd. Suite 222

Trinity, FL 34655

Phone (727) 476-4500

Fax (727) 476-4545

This request and authorization applies to:

_______ All the above-named patient's medical information.

_______ Health care information related to the following treatment, condition, or dates:

____

_______ Other: ____

Signature: ____ **Date**: _____/ _____/ ______