CENTER FOR COUGH

MANDEL SHER, M.D.

11200 SEMINOLE BLVD., SUITE 310
LARGO, FLORIDA 33778
Phone: (888) 632-6844
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MEDICAL RECORDS REQUEST AUTHORIZATION

I hereby authorize the release of my medical records or copies of such records and request that they be sent to the facility listed below. I consent to the release of protected health information which may be necessary to carry out treatment or health care operations and for other purposes that are permitted or required by law.

From:____

Address:____

City:____________________________ State: _______Zip: ______________

To: **CENTER FOR COUGH**
11200 SEMINOLE BLVD., SUITE 310
LARGO, FLORIDA 33778

__________________________________ __________________________________
(Patient's Name) **(Patient's Date of Birth)**

Signed by:________________________________ ________________________________
(Signature of Patient or Legal Guardian) (Relationship to Patient)

____________________________________ ________________________________
(Print Name of Patient or Legal Guardian) (Today's Date)

This authorization will expire one year from date of authorization or:___________________.
{Expiration Date or Defined Event}.