# Todd Kazdan D.O. PA

Board Certified Family Practice

## RECORDS RELEASE AUTHORIZATION

To: _____

DOCTOR OR HOSPITAL

ADDRESS: _____

TEL#: _____

FAX#: _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

**DR. TODD KAZDAN, D.O.**
**6099 STIRLING ROAD, SUITE #220**
**DAVIE, FL 33314**
**TEL: 954-581-7660**
**FAX: 954-587-2075**

THE COMPLETE HISTORY RECORDS IN YOUR POSSESION, CONCERNING ILLNESS AND/OR TREATMENT DURING THE PERIOD

FROM:_____ TO:_____

**NAME:**_____

**DATE OF BIRTH:**_____

**ADDRESS:**_____

**SIGNATURE:**_____ **DATE:**_____

**RELATIONSHIP TO PATIENT IF MINOR:**_____