**Greg A. Cisneros, M.D.**
**33 Old Kings Road North, Suite 2**
**Palm Coast, FL 32137**
**Phone: 386-446-4141**

# Medical Records Release Form

Date: _____

Doctor or Facility: _____

Address: _____

_____

I hereby authorize and request you to release the following records in your possession to Greg A. Cisneros, M.D.

Include Only the Last Year of:

_____EKG
_____Labs
_____Imaging Reports
_____Any other special reports

Patient Name: _____

Address: _____

_____

Date of Birth: _____

Signature: _____

Please **mail** requested records at your earliest convenience to the above address. Thank you in advance.