RECORDS RELEASE AUTHORITY

TO: _____

I, _____
Patient's Name

hereby request that you release to:

Women's Healthcare of Kendall, LLC
Pablo E. Delgado, M.D., F.A.C.O.G.
Obstetrics & Gynecology
10700 North Kendall Drive, Suite 200
Miami, FL 33176
Phone: (305) 270-7999 Fax: (305)270-6788

Reports of my diagnosis, treatments, prognosis, and recommendation, as well as other data pertinent to your treatment of me from _____ to _____.

_____ _____
(Date of Request) **(Patient's Signature)**

_____
(Date of Birth)

_____
(Witness)

_____
(Address)

_____
(City, State, Zip Code)