Lona Sasser D.O., LLC

Obstetrics & Gynecology

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____

Physician or Hospital Name

Address: _____

City/State/Zip: _____

I hereby authorize that my medical records be released to:

Lona Sasser D.O., LLC
1801 N University Drive Suite 209
Coral Springs, FL 33071

Please include the following information:

- ❑ Operative Report
- ❑ Discharge Summary
- ❑ Pathology Reports
- ❑ Labor & Delivery, Prenatal Records
- ❑ Office Records
- ❑ Recent Hospitalization

Reason for release:

- ❑ Insurance change
- ❑ 2nd opinion or consultation
- ❑ Transferring to another physician
- ❑ Labor & Delivery, Prenatal Records
- ❑ Moving out of area

Patient's Name: (print): _____

Date of Birth: _____ SS#: _____

Patient's Name at Time of Procedure / Date of Procedure: _____

Patient's Signature: _____ **Witness**: _____

Date: _____

Signature of employee releasing records: _____

Date: _____