Sarasota Neurology, P.A.
Daniel Kassicieh, D.O.
3501 Cattlemen Road, Ste. B
Sarasota, FL 34232

941-955-5858 (O), 941-955-0044 (F)

AUTHORIZATION FOR RELEASE OF INFORMATION

To:

I hereby authorize the release of all medical information and my medical records to Daniel Kassicieh, D.O.

Patient Name: ____

Address: ____

City: ____________________________ State: _____ Zip: _____

Telephone: _________________________

Date of Birth: _________________ Social Sec. #: ____________

This release is in effect indefinitely from this date of signature, unless revoked by myself in writing.

__________________________ __________________________
Signature (Parent name if minor)

Date: ______________________

Note: Please add any names (maiden, married, etc.) you may have used during treatment: ___________________________________

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