Dr. Sue Mitra, MD
397 N. Wickham Road, Suite 101
Melbourne, FL 32935
Phone: (321) 622-6222 | Fax: (321) 622-6660

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of Birth:_____/_____/_____

Phone Number (_____) _____-_____ Social Security:_____

I request and authorize the release of my healthcare information to the correct physician(s) And/or facility(s) stated below. This request and authorization applies to:

- Any/ All Healthcare Information

- Specific: _____

Medical Records Released From:
Dr.
Phone:
Fax:

Release Medical Records To:
Dr. Sue Mitra
397 N, Wickham Road Suite 101
Melbourne, FL 32935
Phone: **321-622-6222**
Fax: **321-622-6660**

Patient Signature:_____ Date Signed:_____/_____/_____

Witness / Guardian:_____ Date Signed:_____/_____/_____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER SIGNED