

VASCULAR SPECIALISTS OF CENTRAL FLORIDA, INC.

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TO _____
DOCTOR OR HOSPITAL

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE INFORMATION REGARDING
MY MEDICAL CONDITION TO:

**DR. MICHAEL COHEN
DR. JON M. WESLEY**

**DR. CHARLES THOMPSON
DR. ADAM B. LEVITT**

NAME _____ DATE OF BIRTH _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SIGNATURE _____ DATE _____