



Aneley Yegezu Hundae, M.D., FAC
3161 Harbor Blvd Suite A Pt Charlotte, FL 33952
Ph 941-235-8892 Fax 941-883-4494

MEDICAL RECORDS RELEASE

Name: _____

SSN: _____

DOB: _____

I authorize Dr _____ to: () Obtain records from () Send / Release records to

NAME OF HOSPITAL/ DOCTOR/SELF _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

_____ Continued Medical Care _____ New Patient

Most recent records needed: Office Visit EKG Operative Report

Stress Test X-ray Report Echo Report Other: _____

*(Give 3-5 days for Medical Release)

I understand that my records may contain information about alcohol and/or drug treatment, mental health or psychiatric treatment, and /or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose or need as indicated above, I also understand that this consent will expire six(6) months after the date below, or when the information requested has been received / released. A photocopy of this release shall have the same effect as the original.

Patient Signature/ Legal Representative (Relationship) Date

Office use only: Mailed _____ Faxed _____ Pick up in person _____