

**Zoyla Almeida M.D. P.A.**  
**4855 W Hillsboro Blvd., Suite B-13**  
**Coconut Creek, Fl. 33073**  
**954-420-9182 Fax 954-420-9184**

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**PATIENT INFORMATION:**

Patient Name:

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Address:

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City, state, Zip Code:

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Phone Number:

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**RECORDS RELEASED FROM:**

Physician Name or Practice:

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Address:

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City, State, Zip Code:

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Phone/Fax Number:

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**RELEASE RECORDS TO: Zoyla Almeida M.D. P.A. 4855 W Hillsboro Blvd. Suite B13**  
**Coconut Creek, m. 33073**  
**Tel: (954) 420-9182 Fax: 954-420-9184**

I hereby release Dr. Almeida and its employees from any and all liability that may arise from the release of information as I have directed.

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Signature of Patient or Legal Guardian

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Date