SURGICAL SPECIALISTS
OF SOUTHWEST FLORIDA, P.A.
& SWFL VASCULAR CENTER

Ajay Kalra, MD, FACS
Endovascular, Vascular & General Surgery
Jose F. Manibo, MD, FACS
General Surgery
Anthony J. D'Angelo, MD, FACS
Endovascular, Vascular & General Surgery
Thad C. Kammerlocher, MD, FACS
Endovascular, Vascular & General Surgery
Biju K. Thomas, MD, FACS, RPVI
Endovascular, Vascular & General Surgery
John Moss, DO, FACOS, DFACOS
Endovascular, Vascular & General Surgery

Authorization For Disclosure of Medical Record Information

Patient Name: (First, Middle, Last)					
Address:		City		State	
Zip		Date of Birth:			
Phone #:		Email Address:			

I hereby authorize: _____

To: Release my medical record information to Surgical Specialists of Southwest Florida P.A.
6821 Palisades Park Court
Suite 1
Fort Myers, FL 33912
Secure Fax# **239-936-5611**
Email address to send secure file: **appointments@surgspecswfl.com**

Please check all that apply:

☐	I am requesting the following medical records.							
	☐	Visit Summary	☐	Lab Reports	☐	Medications List	☐	Radiology Reports
	☐	History & Physical	☐	Other: List				

Records will be ☐ Mailed ☐ Emailed ☐ Faxed

Signed: Patient		Date:	
Signed: Patient Representative		Date:	
ID Provided:			
Request Taken By Phone (Verification)			