

Bay Surgical Specialists, PA  
960 Seventh Ave. North  
St. Petersburg, FL 33705  
(727) 821-8101 phone  
(727) 825-1357 fax

**RECORDS RELEASE AUTHORIZATION**

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, request that my complete medical  
(print name)

records be released to:

Bay Surgical Specialists, PA  
960 7<sup>th</sup> Ave. North  
St. Petersburg, FL 33705  
(727) 821-8101 Phone  
(727) 825-1357 Fax

Records should include diagnosis, treatment, prognosis and recommendations.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth