ALVIOR
MEDICAL CLINIC
PRIMARY CARE / INTERNAL MEDICINE

TRANSFER OF MEDICAL RECORDS

I (Patient's Name) _____ a resident of
(Patient's Address) _____
with date of birth _____
and Social Security Number or Driver's License ID _____

authorize, **Dr. Jonathan Alvior (Alvior Medical Clinic)**
1905 West Busch Boulevard Tampa, Florida 33612
Phone #: 813-365-3525
Fax #: 813-365-3515

to release my patient health record/summary to:

Name of Doctor: _____
Address: _____
Phone #: _____ Fax #: _____

I understand that this authorization is valid only for 90 days and that I am responsible for any charges incurred for this transfer.

Patient Signature: _____ Date: _____