__/___/17

To Whom It May Concern:

I am requesting the release of my medical records to include my Operative Report, Pathology Report, History and Physical Report, Discharge Summary, Consultation Reports, lab and X-ray reports to:

Susan Kay, R.N.
C/0 Palms of Pasadena Hospital
Continent Ostomy Center
1501 Pasadena Ave South
St. Petersburg, FL 33707

Telephone: 1-800-336-0789
Fax: 1-727-341-7058
E-mail: Susan.Kay@HCAhealthcare.com

_____ _____
Name at time of Surgery Date of Surgery/Service

_____ _____
Social Security Number Date of Birth

Thank you for your attention to my request, I am

_____ _____
Name Signature

_____ _____
Address City, State, Zip

(____)_____
Home Telephone Number