Dr. Daniel Schultz, MD - President

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Continuity of Care Release of Information

Location to request from: _____

Street address:_____

Main phone:_____Fax: _____

Dates of care: _____

I, _____, *authorized person,

to, _____, Date of Birth: _____

Give permission to share/discuss medical and case information both in written or electronic form and verbally over the phone or in person with Dr. Daniel Schultz, MD and his associates, at Final Diagnosis Inc. for continuity of care and review for the above patient.

Sign: _____ _____

*Authorized next of kin: Health care surrogate, executor of estate, spouse, adult child, sibling… Date

Please forward the following specific records when available:

***Electronic records preferred.* Fax to 813-830-7420 Please split files over 250 pages.

Do NOT mail paper records