



Vascular Center
of Naples

**AUTHORIZATION FOR THE RELEASE OF
MEDICAL RECORDS**

To: _____

Fax: _____

Phone: _____

I, _____ hereby authorize the release of any and all of my medical
(*Patient Name and Date of Birth*)
records (including any and all HIV/AIDS records, alcohol and/or substance abuse records, and psychiatric
and/or psychotherapeutic records.)

Information to be released to:

**Russell W. Becker, DO, FACOS, RPVI
&
Ariel Prieto Valdes, MD, RPVI**

**1875 Veterans Park Dr Ste 2203
Naples, FL 34109
P: (239) 431-5884
F: (239) 631-6907**

I request that copies of my medical record be made and mailed or delivered in a timely manner to the above
address or fax number.

I do hereby agree to hold *Vascular Center of Naples*, its agents and staff members free and harmless from any
actions by it or them for alleged invasion of privacy, liable or slander, or defamation, arising in connection with
the disclosure of such information.

Patient Signature

Date