# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ___Myrick den Hartog_____

Previous Name:_____

I request and authorize release healthcare information of the patient named above to:

Name: Anyone - Beneva lakes ALF

Address: 743 S. Beneva Rd

City: Sarasota State: FL Zip Code: 34232

This request and authorization applies to: information relating to the following:

7/4/1947 Date of Birth: _____

484-56-1239 Social Security #: _____

☑ Healthcare condition, or treatment dates:

☑ All healthcare information _____

☐ Other: _____

Patient Signature: Myrick den hartog Date Signed: 7/11/23

Resident/Responsible Party Initials: MDH Date: 7/11/23

Executive Director Initials JO Date _____