

**ISLAND DOCTORS**  
2460 Old Moultrie Road #4  
St. Augustine, Florida 32086  
PH: 904.797.5740 \* FX: 904.797.5749

I, \_\_\_\_\_, give Island Doctors Providers  
(Name)

and Staff permission to speak with,

\_\_\_\_\_ my \_\_\_\_\_  
(Name) (Relation)

in regards to any and all of my medical condition and any information in my medical chart, until otherwise indicated in writing.

Thank you.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date