



Date: _____

To: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I authorize the release of my diagnostic films and/or medical records and request that they be _____ faxed _____, mailed to :

Start to Finish Spine Care
431 Southwest Blvd. N.
St. Petersburg, FL 33703
Phone: 727-822-3500
Fax: 727-822-3228

Patient Name and Date of Birth/Social Security Number

Patient Home Phone and Cell Number

Signature of Patient or Guardian

David M. McKalip, M.D.
Brain and Spine Neurosurgeon

Sara Rizk, D.O.
Physical Medicine Rehabilitation

Physical Therapy
Spinal Injection Specialists

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3W corner of 4th St. N & 62nd Ave. N.