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SUITE 690
DELRAY BEACH, FL 33484
PHONE: (561) 495-2811 FAX: (561) 495-9538

MEDICAL RECORDS REQUEST

DATE:_____

TO:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I HEREBY AUTHORIZE YOU RELEASE TO:

NAME: _____
ADDRESS: _____
CITY_____STATE _____ ZIP _____
PHONE: _____ FAX: _____

ANY INFORMATION INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINIATION RENDERED TO ME DURING THE PERIOD

FROM: _____ TO: _____

PRINTED NAME: _____

BIRTH DATE: _____

SIGNATURE: _____

WITNESS: _____

LEGAL REPRESENTATIVE: _____