LORENA LEWY-ALTERBAUM, M.D., F.A.C.E.

Endocrinology, Diabetes,
Metabolism & Internal Medicine

9720 Stirling Road
Bldg. C, Suite 111
Cooper City, FL 33024

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

Date: __/__/__

I authorize: (Please provide name, address, and phone)

_____

_____

To Release Information from the medical record of: (Full Name and Date of Birth)

_____

To: Dr. Lorena Lewy-Alterbaum
9720 Stirling Road Bldg. C # 111
Cooper City, FL 33024
P: 954-967-0500
F: 954-967-0778

Other Facility: _____
_____
_____

List information to be released. (Be specific) You must initial if psychiatric, substance abuse, or HIV/AIDS records are to be released:

____ Complete medical file exclude psychiatric, substance abuse, HIV/AIDS related information.

____ Complete medical record including psychiatric or substance abuse records.

____ Complete medical records including HIV/AIDS related information.

____ Other: _____

It is my intent that information furnished is prohibited for any purpose other than that stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand I may revoke this consent at any time before the information has been released. A copy of this authorization will be accepted as the original.

I release the organization complying with this request of all responsibility of loss of confidentiality by access and/or copies of records released in compliance of this authorization.

I further direct that only information prior to the date of my signature below be honored; that this request will expire after a period of 90 days from the date below; and that a photocopy of this authorization be granted the authority as the original.

Patient's Signature: _____Date:_____

Patient's Legal Representative or Proxy: _____ Relationship to Patient: _____

Witness: _____ Date: _____