21097 N.E. 27th Ct. Suite 580, Aventura, FL, 33180

REQUEST TO RELEASE MEDICAL RECORDS

DATE: ____________________

TO: ____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

Lawrence A. Berger, M.D., P.A.

The complete history in your possession concerning my care and / or treatment during the period from: ____.

Name: ___________________________________ **Date of Birth:**_______________

Address:____

____

Signature: _____________________________ **Witness:**__________________________

IF RELATIVE, PLEASE STATE RELATIONSHIP:_________________________________

If you have any questions feel free to contact our medical records office at 305-932-5551.

Thank you, Custodian Medical Records