RECORDS RELEASE AUTHORIZATION

Doctor's Name - _____

Phone # - _____ Fax # - _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD OF _____UNTIL_____.

TO:

DAVID LUBETKIN, M.D., F.A.C.O.G
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POLINA GOLDENBERG, CNM, MSN, ARNP
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Phone (561) 300-0600
Fax (561) 300-0601

Name_____ Date_____

S.S.#_____ D.O.B_____

_____ _____
Patient Signature Witness