

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize and request
Marshall Teitelbaum, M.D.
641 University Blvd., Suite 206
Jupiter, FL 33458
561-630-8530
Fax: 561-630-8531

To release confidential professional information, including person, psychological, psychiatric, substance abuse, AIDS-related information, and medical records and opinions resulting from my contacts with them to: **(PLEASE WRITE IN INFORMATION FOR WHO YOU WANT US TO CONTACT)**

Name: _____

Address: _____

Phone: _____ **Fax:** _____

This request specifically includes the following:

- | | |
|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Psychological testing |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Psychosocial History |
| <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Other |

Dates to be covered by reports: From: _____ To: _____ I also authorize _____ (or one of his/her associates) to communicate with _____ regarding all aspects for my treatment, diagnosis and prognosis.

I UNDERSTAND THAT I HAVE NO OBLIGATION TO DISCLOSE THE REQUESTED INFORMATION AND THAT I MAY REVOKE THIS CONSENT AT ANY TIME BY INFORMING ANY OF THE ABOVE NOTED INDIVIDUALS. IN CONSIDERATION OF THIS CONSENT, I HEREBY RELEASE THE ABOVE PARTIES FROM ANY AND ALL LIABILITY ARISING THEREFROM.

Please print patient's name here

Date of Birth

Signature - Patient, Parent or Guardian

Date

Witness

Date