Authorization for Release of Medical Information

I authorize the facility and physicians who treated me to release my medical records for purpose of medical treatment.

From ____

Phone ____________________ Fax ____________________

To: Delia Weiss MD
1 SE 4th Avenue, Suite 206
Delray Beach, FL 33483
Fax: 866 212-8783 Phone: 561 243-8783

Patient Name ____________________ DOB____________________

_X____
Patient signature Date

I, the patient, realize that every effort will be made to handle my medical information securely and confidentially. I indemnify and release all providers from responsibility, in the event that fax or email confidential information is inadvertently accessed by the incorrect recipient.
Note confidentiality: If you are not the intended recipient of this information, please contact sender immediately.