Authorization for Release of Medical Information

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

From Facility: _____

Phone: _____ Fax: _____

Tests Requested: _____

Fax to Delia Weiss MD Internal Medicine Fax (517) 212 – 9866

2828 S. Seacrest Blvd., Suite 208
Boynton Beach, FL 33435
Tel. (561) 243 – 8783.

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**.**

This information is confidential and intended only for the named above. If you are not the intended recipient, you are hereby notified that any disclosure, photocopy, or other distribution of this material is prohibited. Please notify sender of any materials received in error. If there is any difficulty with this transmission, please call 561-243-8783.

Print Patient Name: _____ DOB _____

X Patient Signature:_____ Date _____