David I. Hoffman, M.D.
Steven J. Ory, M.D.
Marcelo J. Barrionuevo, M.D.
Vanessa N. Weitzman, M.D.
Daniel R. Christie, M.D.
Marc R. Gualtieri, M.D.
Laurice Bou Nemer, M.D.
Luis R. Hoyos, M.D.

(954) 247-6200

# PATIENT CONSENT TO RELEASE MEDICAL RECORDS/LABORATORY TESTS

I authorize the release of medical information to the individual(s) noted below:

1. NAME OF PATIENT –PLEASE PRINT
2. ______________________________

SOCIAL SECURITY NUMBER (LAST 4)

______________________________

3. My lab results may be released to my partner Yes ☐ No ☐
4. Medical information may be released to my past or future treating physician Yes ☐ No☐
5. Physician's Name and Address

______________________________

______________________________

______________________________

6. Medical information/lab results may be released to another person or party (please list).

______________________________

______________________________

______________________________

**Preferred Phone #** ______________________________

☐ OK to leave voice message at preferred phone

1. NAME OF PARTNER (IF RELEVANT) –PLEASE PRINT
2. ______________________________

SOCIAL SECURITYNUMBER (LAST 4)

______________________________

3. My lab results may be released to my partner Yes ☐ No ☐
4. Medical information may be released to my past or future treating physician Yes ☐ No☐
5. Physician's Name and Address

______________________________

______________________________

______________________________

6. Medical information/lab results may be released to another person or party (please list).

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**Preferred Phone #** ______________________________

☐ OK to leave a voice message at preferred phone

______________________________ ____________ ______________________________ ____________

SIGNATURE DATE SIGNATURE DATE

______________________________ ____________ ______________________________ ____________

WITNESS (STAFF USE ONLY) DATE WITNESS (STAFF USE ONLY) DATE

Revised 3/2021