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.,FACOG
BOCA MIDWIFERY
1001 NW 13TH ST
Suite 101A
Boca Raton, FL 33486

Phone (561) 300-0600
Fax (561) 300-0601

Name _____ Date_____

S.S.# _____ D.O.B_____

_____ _____
Patient Signature Witness