

## REQUEST FOR RELEASE OF MEDICAL RECORDS



\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Street

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

**I request that my medical records be released to:**

**Marc E. Lieberman, M.D., F.A.C.S.  
1600 36<sup>th</sup> Street, Suite A  
Vero Beach, FL 32960  
Phone 772.569.7800 Fax 772.569.9252**

\_\_\_\_\_  
Patient's Name

**X** \_\_\_\_\_

**Patient or Legal Representative Signature**

\_\_\_\_\_  
Street

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

### CONSENT TO RELEASE INFORMATION

To assist in your care, it may be helpful to discuss your Protected Health Information with another person in addition to you. Typically, this could be your spouse, child, caregiver, etc. Please indicate below with whom we may speak or leave a voicemail:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone

Neither Dr. Lieberman nor any member of his office staff may discuss your case with anyone not specifically listed above.

**X** \_\_\_\_\_

**Patient or Legal Representative Signature**