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 36th 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