Request For Release Of Medical Records From:

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.
Katsiaryna Huseva Bailor, M.D.
1600 36th Street, Suite A
Vero Beach, FL 32960
Phone 772.569.7800 Fax 772.569.9252

Patient's Name

X

Signature of Patient or Legal Representative

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

Signature of Patient or Legal Representative