MEDICAL RECORDS RELEASE

**FROM ANOTHER PHYSICIAN**

Patient Name: _____ DOB: _____

Address: _____ City: _____ State_____ Zip_____

The above named patient is now under our care at our facility. We have been informed that he/she has been treated in your facility. Please send us all relevant information on this patient at your earliest convenience. I, hereby authorize

Doctor/ Facility: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

To furnish the information specified above without restriction of any kind, from my medical chart to:

*Weissmann & Mehrel, M.D., P.A.*
*400 Arthur Godfrey Road # 300*
*Miami Beach, Fl 33140*
*dermwm@gmail.com*
*Fax: 305-674-9014*

Patient Signature: _____ Date: _____

**TO ANOTHER PHYSICIAN**

I, _____ waive all responsibility of Weissmann & Mehrel, M.D., P.A., regarding the confidentiality of information released to the aforementioned party. I hereby authorize Weissmann & Mehrel, M.D., and P.A., to furnish my medical records to:

Doctor/Facility: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

Patient Signature: _____ Date: _____