AUTHORIZATION FOR RELEASE OF ALL MEDICAL RECORDS

Office use only:

To: ----------

Address ----------

City ----------

State ----------

Zip Code ----------

I hereby request that all of my Medical Records with respect to any illness including mental illness, drug or alcohol abuse and HIV – AIDS testing or treatment be released to:

IDL MEDICAL PA
Diana Gorokhovsky, D.O.
10075 Jog Road Suite 101
Boynton Beach FL 33437
PH (561)734-5484
FX (561)734-5485

Patient Name: ----------

Social security # ----------

Date of Birth ----------

Signature of patient ----------

Witness ---------- **Date: ----------**

A Photostat copy of this authorization is to be considered as valid as the original.