CONSENT TO RELEASE MEDICAL RECORDS

I hereby authorize Dr. Michael Benjamin/Frank Rodriguez/Kurt Christopher, M.D. or Pamela Graham, A.R.N.P.

_____To **RELEASE** copies of my medical records to:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Fax: (_____) _____ Telephone: (_____) _____

_____To **RECEIVE** copies of my medical records from:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Fax: (_____) _____ Telephone: (_____) _____

PLEASE FORWARD MEDICAL RECORDS TO:
Michael J. Benjamin, M.D.
Frank Rodriguez, M.D.
Kurt Christopher, M.D.
Pamela K. Graham, A.R.N.P.
7777 North University Drive, Suite 102
Tamarac, Florida 33321
Fax: (954)726-2896 | Office: (954)720-7777

Reason for records to be released: _____

Medical records to be released: _____

Date(s) of service: _____

Dr. Michael Benjamin/Frank Rodriguez/Kurt Christopher, M.D. and Pamela K. Graham, A.R.N.P are released from any legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

I understand that this release may be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this account. To revoke this consent, written notice must be given. I understand that this release will expire 60 days from the date signed below.

I understand that my records may contain information pertaining to my diagnosis or treatment of medical, psychiatric, AIDS/ARC/HIV testing and alcohol or drug abuse condition(s). I also understand that any topic discussed during my medical treatment was documented and therefore will be released.

_____ _____ _____
Patient Printed Name Patient Signature Date

Social Security Number: _____ - _____ - _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____