

**REQUEST TO OBTAIN MEDICAL INFORMATION**



**DANIEL BENDETOWICZ, MD, PA  
INTERNAL MEDICINE**

I do hereby authorize:

\_\_\_\_\_  
PRACTICE NAME

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY STATE ZIP

\_\_\_\_\_  
PHONE NUMBER FAX NUMBER

to release to:

**DANIEL BENDETOWICZ, M.D., P.A.**      **PHONE: (239) 985-1050**  
**6840 INTERNATIONAL CENTER BLVD.**      **FAX: (239) 985-1060**  
**FORT MYERS, FL 33912**

the following medical information, including sexually transmitted diseases, HIV/Aids, psychiatric, psychological, alcohol and drug abuse:

- ALL RECORDS
- HISTORY & PHYSICAL
- PROGRESS NOTES
- CONSULTATION
- LABORATORY RESULTS
- RADIOLOGY TEST
- OTHER: \_\_\_\_\_

for the purpose of:

- CONTINUITY OF CARE
- UPDATE ON PATIENT MEDICAL CONDITION
- OTHER: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Daniel Bendetowicz, M.D., P.A. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from the date of signature.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact Daniel Bendetowicz, M.D., P.A.

\_\_\_\_\_  
PATIENT NAME DATE OF BIRTH

\_\_\_\_\_  
SOCIAL SECURITY NUMBER PHONE NUMBER

\_\_\_\_\_  
PATIENT SIGNATURE OR LEGAL REPRESENTATIVE SIGNATURE DATE

\_\_\_\_\_  
IF SIGNED BY LEGAL REPRESENTATIVE, STATE THE RELATIONSHIP TO THE PATIENT

\_\_\_\_\_  
WITNESS SIGNATURE

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