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.
6840 INTERNATIONAL CENTER BLVD.
FORT MYERS, FL 33912

PHONE: (239) 985-1050
FAX: (239) 985-1060

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