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