Monica Daniel M.D., F.A.C.O.G.
Obstetrics and Gynecologic Surgery

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (PLEASE PRINT)

Name: ______________________________ Date of Birth: ____________

Social Security #: ______________________________

Address: ______________________________

City: ____________________ State: __________ Zip: ____________

PLEASE RELEASE MY RECORDS:

TO:
Name: ____________________

Address: ____________________

____

Phone: ____________________

Fax: ____________________

FROM:
Name: MONICA DANIEL M.D.

Address: 17759 S.W. 2ND STREET

Pembroke Pines, Fl 33029

Phone: 954-399-8875

Fax: 954-505-4137

REQUEST SPECIFIC ITEMS:

_____Office Visits
_____Ultrasound/Radiology
_____Pathology
_____Complete Records
_____Operative Reports

_____Pap Smear
_____Mammogram
_____Lab Results
_____Bone Density (DEXA)

There is no charge associated with having my medical records sent directly to another physician or provider to facilitate the continuity or transfer my care.

If I have requested the records personally, there will be a charge to cover the cost of the duplication and this charge is allowed by law. (The fee = $1.00 per page for the first 25 pages, $0.25 for each additional page) _____(Initials)

BY MY SIGNATURE I AUTHORIZE RELEASE OF MY MEDICAL RECORDS
Patient: ______________________________ Date: ______________

****Please note that a minimum of 5 working days is required to copy and send medical records****

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