Weston Family Medicine
2300 North Commerce Parkway
Suite 313
Weston, FL 33326
Office: 954-217-2707 Fax: 954-217-2709

I herby authorize Weston Family Medicine to:

_____Release medical records to: _____Request medical records from:

Facility Name: _____
Doctor Name: _____
Office Phone and/or Fax: _____

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

This consent may be revoked any time by written notice. This consent expired in 90 days.

Information to be released/received:
(if nothing is circled please only submit medical summary)

Medical Summary ER Summary Hospital Notes
Most Recent Office Notes Most Recent Labs Most Recent ECG Most Recent X-Ray

Date of ER/ Hospital Admission/ Office Visit: _____

Patient Name: _____

Patient Date of Birth: _____

Date: _____

_____
Signature of Patient/Guardian