Fern TaiSenChoy-Bent M.D. LLC

2964 N State Road 7, Suite 320
Margate, FL 33063
(954)-796-0111

Dr._____

Office Address:_____

Phone:_____Fax:_____

I,_____, hereby request that you,

Release to Request from

Fern TaiSenChoy-Bent M.D. LLC
2964 N State Road 7, Suite 320
Margate, FL 33063
Ph: (954)-796-0111
Fax: (954)-796-0120

All records include my diagnosis, treatment, prognosis, lab work, recommendation and other data pertinent to your treatment of me.

Other:_____

Duplicating Fees:

I understand:

Dr. Fern TaiSenChoy-Bent's office policy is to charge for copying records at a flate rate of $1 for pages 1-25, and $0.25 a page thereafter.

NO EXCEPTIONS

Original records will remain in our office. If you need another copy, you will be billed again.

Date of Birth:_____Pt. Name:_____

Pt. Signature:_____Todays Date:_____