DAVID I. LUBETKIN, MD, FACOG
DANIEL LORIDO, MD, MPH
BOCA MIDWIFERY
Obstetrics • Gynecology • Infertility

Doctor's Name: _____

Practice Specialty:_____

Phone #: _____ Fax #: _____

I, _____ hereby authorize and request you to release all medical records in your possession, concerning all treatments, care and or any illness while under your care to the below provider:

DAVID LUBETKIN, MD, FACOG
DANIEL LORIDO, MD, MPH
BOCA MIDWIFERY
1001 NW 13TH ST, Suite 101A
Boca Raton, FL 33486
Phone (561) 300-0600 / **Fax (561) 300-0601**

_____ I understand that signing this is voluntary and I may revoke it at any time.

_____ It is my intention to transfer Obstetrics treatment into the care of Dr. David Lubetkin, MD, FACOG ; Dr. Daniel Lorido, MD, MPH; BOCA MIDWIFERY.

_____ It is my intention to provide records only to assist with the current treatment I am seeking under the care of Dr. David Lubetkin, MD, FACOG ; Dr. Daniel Lorido, MD, MPH; BOCA MIDWIFERY and care with your office will continue.

Name _____ Date_____

S.S.# _____ D.O.B_____

_____ _____
Patient Signature Witness
