Renata Teytelbaum MD, AMMGC
Family Practice
Age Management Medicine

585 Main Street, Suite 101
Dunedin, Florida 34698

P 727.734.6777
F 727.734.6440

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO: _____ DATE: _____

ADDRESS: _____

I hereby authorize and request you to release any and all information which you may possess relating to my examination and illnesses, including psychiatric and/or psychological information, which may be a part of my medical record, covering the period from: _____ to _____ to be forwarded to:

RENATA TEYTELBAUM, MD
585 Main Street, Suite 101
Dunedin, FL 34698
****Please do not fax over 20 pages****

PATIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

PATIENT SIGNATURE: _____

Relationship, if other than patient: _____

WITNESS: _____

Authorization must be signed by the patient or by the parents if patient is a minor, or by the nearest relative or legally appointed guardian if patient is physically or mentally incompetent.