

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.