**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I hereby authorize and request

**Marshall Teitelbaum, M.D.**
**641 University Blvd., Suite 206**
**Jupiter, FL 33458**
**561-630-8530**
**Fax: 561-630-8531**

To release confidential professional information, including person, psychological, psychiatric, substance abuse, AIDS-related information, and medical records and opinions resulting from my contacts with them to:

**Name:** _____

**Address:** _____

_____

**Phone:** _____ **Fax:** _____

This request specifically includes the following:

( ) Discharge Summary
( ) Progress Notes
( ) Laboratory Results
( ) Psychological testing
( ) Psychosocial History
( ) Other

Dates to be covered by reports: From: _____ To: _____ I also authorize _____ (or one of his/her associates) to communicate with _____ regarding all aspects for my treatment, diagnosis and prognosis.

**I UNDERSTAND THAT I HAVE NO OBLIGATION TO DISCLOSE THE REQUESTED INFORMATION AND THAT I MAY REVOKE THIS CONSENT AT ANY TIME BY INFORMING ANY OF THE ABOVE NOTED INDIVIDUALS. IN CONSIDERATION OF THIS CONSENT, I HEREBY RELEASE THE ABOVE PARTIES FROM ANY AND ALL LIABILITY ARISING THEREFROM.**

_____ _____
Please print patient's name here Date of Birth

_____ _____
Signature - Patient, Parent or Guardian Date

_____ _____
Witness Date