Holistic Medicine of Belleair

Renata Teytelbaum MD, AMMGC

Family Practice

Age Management Medicine

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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

2310 West Bay Drive, Suite 101

Largo, FL 33770

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.