Caren J. Bennett, M.D., P.A.

7261 Sheridan Street, suite 100-C
Hollywood, FL 33024
(954) 441-6226
Fax (954) 443-3994

MEDICAL RECORDS SERVICES
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS

Patient: ______________________________

D/O/B: ______________________________

I, ___________________________________ hereby authorize ____________________
(Patient, Parent/Guardian or Personal Rep.)
to disclose medical records obtained in the course of the diagnosis and/or relating to:

_____**ALL MEDICAL RECORDS**
_____**LABS**
_____**X-RAYS**
_____**OTHER** ___________________________

This information is to be released to Caren J. Bennett, M.D., P.A.

And such disclosure shall be limited to the following specific types of information:

I hereby release Caren J. Bennett, M.D., P.A. from any liability which may result from this release of confidential medical records which may arise as a result of the use of the information contained in the records released, and as such, I relieve and hereby agree to hold Caren J. Bennett, M.D. free and harmless from any and all liability arising out of this release. This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance herein, and if not earlier revoked, this consent will automatically expire after the requested information has been provided.

____
Patient, Parent/Guardian or Personal Representative

____
DATE

____
Witness

____
DATE