Health Internal - Dr Dov Pickholtz DO
5341 West Atlantic Ave #301
Delray Beach, FL 33484
Office: 561-450-9933 - Fax (561) 450-9934

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____
Date of Birth: _____
Phone Number: _____

I respectfully authorize and request that you release copies of my medical records to: Health Internal/Dr Dov Pickholtz, DO. I authorize release of information of my medical record: I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. Should my case require review by a governing agency or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for this review.

Patient (or legal representative) _____ **Date:** _____
Relationship to Patient: [ ] Self [ ] Guardian [ ] Power of Attorney
Witness: _____ **Date:** _____