



**INTERNAL MEDICINE**  
 ALAN R. KUTNER, M.D.  
 IVAN M. JONAS, M.D.  
 JANE S. COHEN, M.D.  
 MARTIN DROST, M.D.  
 JASON L. RADICK, M.D.  
 LEILANY IRIZARRY-COLON, M.D.  
 BRIAN G. PACTHER, D.O.  
 BARBARA CORREAL PEREZ, M.D.

**GASTROENTEROLOGY  
 & ENDOSCOPY**  
 DAVID COHEN, M.D.  
 ARIN H. NEWMAN, M.D.  
 DANIEL L. WOLFSON, M.D.

**MEDICAL RECORDS RELEASE FORM**

Patient Name: \_\_\_\_\_ Acct #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to release my medical records and/or Protected Health Information including those portions, if any, of my medical records pertaining to HIV testing diagnosis or treatment, Drug or Alcohol Abuse and treatment of Psychiatric treatment to:

**PHYSICIAN'S GROUP OF SOUTH FLORIDA, P.A.**

**4300 Alton Rd Suite 810  
 Miami Beach, Florida 33140  
 Tel: 305-674-5925 \*Fax: 305-674-5927**

**1801 NE 123<sup>rd</sup> Street Suite 405  
 North Miami, Florida 33181  
 Tel: (305)692-6100\* Fax :( 305)692-6101**

This authorization is for the listed date(s) of treatment from \_\_\_\_\_ to: \_\_\_\_\_

Please specify portion (s) of medical records requested: \_\_\_\_\_

By authorizing the release of the above mentioned records, I understand that medical records are confidential and cannot be disclosed without specific written consent of the person to whom they pertain, or as permitted by law. I also understand that, as regulated under the HIPPA guidelines, once records are released, the record custodian or its employees have no responsibility or liability that may arise regarding any aspect of this authorization.

Furthermore, I understand I may revoke this consent in writing at any time, except where disclosure has already been made or upon occurrence of the purpose for which this disclosure is authorized.

The authorization for Release of information (unless expressly revoked earlier) expires six (6) months from the date the release was signed by the patient or authorized agent.

I agree to accept responsibility for payment of the fee charged for the information requested. I understand the fees charged are allowable by Florida Law. The copying fee is waived only when photocopies are for the purpose of continuing medical care.

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Patient's Printed Name

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Witness Signature

\_\_\_\_\_  
 Witness's Printed Name

\_\_\_\_\_  
 Date

**Mt. Sinai Medical Center  
 4300 Alton Rd Suite 810  
 Miami Beach, Florida 33140  
 Tel: 305-674-5925 \*Fax: 305-674-5927**

**Causeway Square  
 1801 NE 123<sup>rd</sup> Street Suite 405  
 North Miami, Florida 33181  
 Tel: 305-692-6100\* Fax: 305-692-6101**