Richard Rosen, D.O.
Owen Peller, M.D., F.A.C.P., F.A.C.C.
Sondra Aiken, M.D.
Debi Kuiper-Tomas, PA-C, MHSC

4801 S. University Suite 104
Davie, Fl 33328
Office: (954) 434-1705
Fax: (954) 434-1882

REQUEST FOR MEDICAL RECORDS:

Today's Date:___________________________

TO: ____

PHYSICIANS NAME

____

ADDRESS

____

CITY STATE ZIP CODE

____________________________ ____________________________

PHONE NUMBER FAX NUMBER

I hereby request that my medical records which may include psychiatric, alcohol or drug abuse treatment and/or HIV test results, all but not limited to lab results, radiology and consultation notes to be released to:

Associates in Family Practice
4801 South University Drive, Suite 104
Davie, FL 33328

PLEASE FAX ALL RECORDS TO (954)434-1882 ATTN:ADAM

____________________________ ______________________

PRINT NAME DATE OF BIRTH

FROM:________________________ TO:___________________

DATE OF RECORDS DATE OF RECORDS

______________________________ ____________________________

PATIENT SIGNATURE DATE

Q:\Associates in Family Practice Documents\Medical Records