



Eugenio Menendez, D.O., P.A.

d/b/a **Pompano Beach Internal Medicine**

Office of **Eugenio L. Menendez, D.O., F.A.C.P.**

Board Certified -- Internal Medicine

www.PompanoBeachInternalMedicine.com

REQUEST FOR MEDICAL RECORDS

Please release my medical records from:

PROVIDER: _____

ADDRESS: _____

PHONE: _____ FAX: _____

Please release ALL records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests and x-ray to:

POMpano BEACH INTERNAL MEDICINE

Eugenio Menendez, D.O., P.A.

1600 E. Atlantic Blvd, First Floor

Pompano Beach, FL 33060

PH: 954-942-2247 Fx: 954-942-2265

PATIENT'S NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ PHONE: _____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE. This authorization includes release of information concerning HIV testing or treatment of ADIDS, AIDS related conditions, drug or alcohol abuse and drug related conditions, alcoholism and/or psychiatric/psychological conditions.

SIGNATURE: _____ DATE: _____

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