
**REQUEST FOR MEDICAL RECORDS**

I _____, REQUEST THAT A COPY OF MY MEDICAL RECORDS BE RELEASED FROM THE FOLLOWING OFFICE:

Dr. _____

Phone #: _____

Fax #:_____

Address: _____

_____

And Forwarded to: Dr Lanalee Araba Sam
2466 East Commercial Blvd Ste 101
Fort Lauderdale, FL 33308
(P) 954-776-4877 (F) 954-776-1399

Patient Name:_____ Date of Birth: / /

Signature: _____ Date: / /