## RECORD RELEASE REQUEST FORM

DATE: ______________________

To: Ana M. Lamas, M.D.
Medical Records Department

Patient's name: ________________________________________ DOB: ______________________

**** I HEREBY AUTHORIZE Lamas Medical Center TO RELEASE MY RECORDS TO:**

TO: ____________________________________________________________

PHONE # ______________________________ FAX#________________________________

*Office Notes: ________ *X-Rays: ________

*Allergy Test: ________ *CT- Scan: ________

*Patch Test: ________ * Hospital Notes: ______________________

*Lab work: ________ * Other: ______________________________

*NOTES:____________________________________________________________

___________________________________________________________________

___________________________________________________________________

Signature: ________________________________________ Date: ______________________

Please fax signed release to: Medical Record Department
Fax: 305.648.0140 / 305.529.3498