HERSHMAN
MEDICAL CENTER

Lloyd Hershman, M.D.
General Practice
Diplomate American Board of Pediatrics

Kenneth Hershman, M.D.
Diplomate American Board of Internal Medicine
Geriatric Medicine

HEALTH INFORMATION RELEASE

Patient's Request and Authorization

I _____, DOB: _____ request and authorize
□ Hershman Medical Center OR □ _____, fax: (___) _____-_____ to provide/obtain a copy of the specific health and medical information as described below.

This request applies to the following information:

_____ All health information pertaining to any medical history, mental or physical (optional) except:
_____.

_____ Only the following records or types of health information (including any dates):

Record Type:	Date:
_____	_____
_____	_____
_____	_____

The designated information is to be sent to:

☐ Patient listed above

☐ Authorized designated person (Print Name):
_____

☐ Physician's Office:
Name: _____
Address: _____
Phone: _____
Fax: _____

☐ Hershman Medical Center, P.A.
Attn: Medical Records Coordinator
11479 SW 40th Street, Miami, FL. 33165
Tel. 305-221-7235, Fax: 305-220-1847

SIGNATURE: _____ Date: _____
(PATIENT/AUTHORIZED DESIGNATED PERSON)

If signed by an authorized designated person, state your legal relationship to the patient
_____.

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Witness: _____ This release expires: ____/_____/_____.
(Signature Required)