Marcy Galinsky, M.D., P.A.

Diplomate, American Board of Family Practice

8700 N. Kendall Drive, Suite 105
Miami, Florida 33176
Telephone (305) 271-3373
Fax (305) 271-8618
galinsky@bellsouth.net

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO:_____ DATE:_____

FAX/ADDRESS:_____

NAME OF PATIENT:_____ DOB:_____

ITEMS REQUESTED:_____

_____

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Please release my medical records and information regarding my treatment, hospitalization, and/or outpatient care for my condition, including, but not limited to, psychological or psychiatric impairment, drug abuse, and or alcoholism, sickle cell anemia, AIDS (Acquired Immune Deficiency Syndrome), AIDS-related complex (ARC) and HIV antibody testing to:

MARCY GALINSKY, M.D.
8700 N KENDALL DR. SUITE 105
MIAMI, FL 33176
(305)271-3373 phone
(305)271-8618 fax
GALINSKY@BELLSOUTH.NET

Signature_____ DATE:_____