Lebowitz Medical Group P.A.
3250 Cove Bend Dr.
Tampa, FL 33613

Authorized for Release of Medical Information

Authorize: Lebowitz Medical Group P.A.
3250 Cove Bend Dr.
Tampa, FL 33613

Phone: (813) 978-1100
Fax: (813) 978-1120

To Obtain From _____

To Release To_____

For the purpose of: _____

Name of Doctor or Facility: _____

Address and Phone Number:_____

Office Notes ____ *X-ray Reports_____* *Labs_____*
EKG's _____ *Other_____*

__I understand that the information to be release may include medical information for the treatment of psychiatric disorders, mental illness, alcohol/substance abuse, and results of tests designed to identify the HIV, its antigen/Antibody, of AIDS.
__I understand that if I am picking up records myself that if they are not picked up within 30 days, I understand that the copy of my records will be shredded.
__I understand that if the records are for myself, there will be a charge.
__ I understand that this Consent for Medical Information is subject to revocation at any time, except to the extent that action has already been taken. Unless otherwise stated below, this consent will expire in 90 days from the date set forth below.

Signature:_____

Date:_____