ALEX M LAM, MD
INSTITUTE FOR RHEUMATOLOGY & INTEGRATIVE MEDICINE
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REQUEST FOR RECORDS RELEASE

From Institute For Rheumatology & Integrative Medicine (IRIM)
d.b.a. Alex M. Lam, M.D., P.A.

Physician's Name: _____

Patient Name: _____

Date of Birth: _____ Phone Number: _____

The following individual has requested that we release their medical records to your office.

I hereby authorize the release of all necessary medical records from Institute for Rheumatology & Integrative Medicine (IRIM) d.b.a. Alex M. Lam, M.D., P.A. to:

☐ Self or

☐ Physician's Name: _____

Street Address: _____

City: _____ State: _____Zip:_____

Phone: _____Fax: _____

Please sign:

Patient's Signature: _____ Date: _____

(Or Guardian if patient is a minor) (Signature is only valid for 90 days from date signed)

Street Address: _____

City: _____ State: _____Zip:_____