ALEX M LAM, MD
INSTITUTE FOR RHEUMATOLOGY & INTEGRATIVE MEDICINE
600 NORTH HIATUS ROAD SUITE 105 PEMBROKE PINES FL 33026
WWW.GOIRIM.COM PHONE 954.620.0011 FAX 954.620.0238

REQUEST FOR RECORDS RELEASE

FROM OTHER OFFICE

Physician's Name: _____

City: _____ State: _____Zip:_____

Phone: _____Fax: _____

The following individual has aksed us to request that their medical records be released and forwarded to our office:

Patient Name: _____

Date of Birth: _____ Phone Number: _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file. Thank you for expediting this request. Please send these records to our office address or fax shown above.

I hereby authorize the release of all necessary medical records to Alex M. Lam, M.D., P.A. I wish for them to be forwarded as soon as possible.

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:_____