



INSTITUTE FOR RHEUMATOLOGY & INTEGRATIVE MEDICINE  
160 S Flamingo Road, Pembroke Pines, FL 33027  
WWW.GOIRIM.COM PHONE 954.620.0011 FAX 954.620.0238

## REQUEST FOR RECORDS RELEASE

*From Institute For Rheumatology & Integrative Medicine (IRIM)*

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: \_\_\_\_\_