BOCA RATON NEUROLOGIC ASSOCIATES

REQUEST OF RELEASE OF MEDICAL RECORDS

I, (NAME) _____ (DOB) _____

ADDRESS: _____

PHONE: _____

Hereby request that my complete medical records be forwarded

TO / FROM:

BOCA RATON NEUROLOGIC ASSOCIATES

Lorin Michael Graef, M.D.

Adam Dov Falchook, M.D. **Annet Ella Falchook, M.D**.

1050 NW 15th Street, Suite 216A
Boca Raton, FL 33486
Phone 561-338-8484
Fax 561-338-8492

TO / FROM :

_____

_____

_____

Specific Records Requested: _____

_____

Signature:_____ Date: _____