

Partners in Women's Health

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600 Heritage Drive, Suite 210
Jupiter, Florida 33458
(561) 354-1515

Release of Medical Records

I, _____
Patient name (please print)

Date of Birth: _____ Social Security #: _____

Hereby Request That My Records Be Released To:

Partners in Women's Health
600 Heritage Drive Suite 210
Jupiter, Florida 33458
Phone(561) 354-1515\
Fax(561) 354-1516

Requesting: All Records (including HIV test results)

Specific: _____

Requesting Records From: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: (____) - _____ Fax #: (____) - _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____