OFFICE OF DR. STEVEN KANFER, M.D.
3502 Henderson Blvd. Suite 302
TAMPA, FLORIDA 33609
PHONE (813) 250-0224 ◆ FAX (813) 250-9019

____ ____________________________
Patient's Name   Patient's Social Security #

____ ____________________________
Patient's Date of Birth   Patient's Medical Record

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

By signing below, I authorize the office of Dr. Steven Kanfer M.D. to exchange with_______________ Release to_____________ Receive from________________ verbal_______ written_______ Verbal and written_________ information regarding my medical treatment, including psychological/psychiatric and alcohol/substance abuse treatment information, and HIV/AIDS test results with:

____
Name

____
Street Address

____
City, State, Zip Code

For the purpose of ____

More specifically, please send copies of: (Initial next to either A or B)

A. ______ All records in the custody of ____

B. ______ ONLY the following: (Check records being requested)

__________ Records of Treating Physician ___________________________________Only
(Specify Physician's Name)
__________ Evaluation – Initial
__________ Progress Notes
__________ Medication Report
__________ Psychological Test Results
__________ X-rays
__________ Lab Results
__________ Verbal Report
__________ Billing
__________ Other: ____

I understand that I may be charged for the copying of these patient records and payment is expected at the time I receive copies from the office of Dr. Steven Kanfer, M.D. This authorization will expire one year after the date of signing.

______________________________________ ____________________________
Signature of Patient or Authorized Representative   Date

____
Relationship to Patient (Self/Parent/Legal Guardian/Personal Representative/Other)

______________________________________ ____________________________
Signature of Witness   Date