Robert S. Tomchik, M.D., P.A.

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MEDICAL RECORDS REQUEST

Records
Requested from:_____

Phone:(_____)_____ Fax:(_____)_____

I authorize the release of my medical records to:

Robert S. Tomchik, M.D., P.A.
3161 SW 160th Avenue
Miramar, FL 33027-4214

Phone: (954) 450-3550
Fax: (954) 450-3557
www.MiramarMedicine.com

Patient Name:_____

Date of Birth:_____ Social Security Number:_____

Patient Signature:_____ Date:_____