Jeffrey Marcus, M.D., M.P.H., P.A.

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Authorization for Release of Protected Health Information

Patient's Name: _____ SS#:_____

Date of Birth: _____ Phone#: _____

Address: _____

_____

I hereby authorize _____

To disclose the following information from my Protected Health Information Records to:

Name: _____ Address: _____

Phone: _____ Fax: _____

Name: _____ Address: _____

Phone: _____ Fax: _____

Name: _____ Address: _____

Phone: _____ Fax: _____

I understand this authorization may be revoked at any time by sending a written request to Jeffrey Marcus, M.D., M.P.H., P.A.

Signature: _____ Date: _____