DR. DAVID MAKOVER, M.D., F.A.C.P., F.A.C.R
2900 N MILITARY TRAIL
SUITE 244N
BOCA RATON, FL 33431

PHONE: 561-367-0078
FAX: 561-367-0529

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: **DR. DAVID MAKOVER**

Address: **2900 NORTH MILITARY TRAIL, SUITE 244N**

City: **BOCA RATON** State: **FL** Zip Code: **33431**

This request and authorization applies to:

LABS **MRI** ______________________

NOTES **NERVE CONDUCTION TEST**

BONE DENSITY **COMPLETE MEDICAL RECORDS**

XRAYS

Patient Signature: ______________________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.