SENIOR MEDICAL ASSOCIATES
LEADERS IN SENIOR HEALTH CARE

Medical Records Request

☐ 3840 Coconut Creek Parkway
Coconut Creek, FL 33066
P: (954) 580-8867
F: (954) 580-8942

☐ 7421 North University Drive, Suite 312
Tamarac, FL 33321
P: (954) 726-2262
F: (954) 726-7048

☐ 9633 West Broward Boulevard, Unit 9
Plantation, FL 33324
P: (954) 616-5163
F: (954) 306-6955

☐ 2929 North University Drive, Suite 210
Coral Springs, FL 33065
P: (954) 757-1909
F: (954) 757-3909

☐ 7800 West Oakland Park Boulevard, Suite 121
Sunrise, FL 33351
P: (954) 870-5671
F: (954) 870-5677

☐ 735 East Oakland Park Boulevard
Oakland Park, FL 33334
P: (954) 990-8382
F: (954) 990-7561

☐ 2305 West Hillsboro Boulevard
Deerfield Beach, 33442
P: (954) 421-7420
F: (954) 421-7424

☐ 1855 North Corporate Lakes Blvd. Suite 2
Weston, FL 33326
P: (954) 659-9690
F: (954) 659-9694

☐ 601 North Flamingo Road, Suite 202
Pembroke Pines, FL 33028
P: (954) 248-6795
F: (954) 248-6797

☐ 1759 North University Drive
Hollywood, FL 33024
P: (954) 842-2175
F: (954) 842-2924

Patient Name: _____

Social Security Number: _____

Date of Birth: _____/_____/_____

I hereby authorize:

Doctor:_____

Phone: _____FAX:_____

Doctor:_____

Phone: _____FAX:_____

Doctor:_____

Phone: _____FAX:_____

Doctor:_____

Phone: _____FAX:_____

Doctor:_____

Phone: _____FAX:_____

All medical records and / or information, including those portions if any pertaining to HIV testing, AIDS diagnosis or treatment, Drug or Alcohol abuse and treatment, or Psychiatric treatment to Senior Medical Associates. I understand that the medical records are confidential and cannot be disclosed without specific written consent of the person to whom they pertain or permitted by law. I further understand that once released, the record custodian, or its employees have no responsibility of liability that may arise regarding any suspect of this authorization. I agree to accept responsibility for payment of any charges for the information requested. I understand that fees charged are within the allowable by Florida Law. The copying fee is waived only when photocopies are for the continuing medical care.

Patient Signature: _____ Date: _____

Witness Signature: _____Date: _____