Authorization to Release Health Information

_____ _____

Patient Name Date of Birth

_____

Address City/State/Zip Phone Number

Release Records From: **Send Records To:**

_____

Dr. Georges Jabaly

4405 N. Holland Sylvania # 104

_____ **Toledo, Ohio**

43623

_____

Fax: 419.882.4795

If FAXING Medical Records, Please no more than 25 pages.

This information is being disclosed for the purpose of continuation of health care.

For healthcare covering the periods of: (Circle) All or From: _____ To: _____

(Circle) : Complete Health Record Or History and Physical Progress Notes

Discharge Summary X-rays/Ultrasounds Labs Consultations

I understand that the information in my health record may include information relating to sexually transmitted disease, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services and treatment for alcohol and/or drug abuse.

I understand that if I request copies for myself or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

Unless otherwise indicated, this authorization will expire in one hundred eighty (180) days from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be revoked in writing at anytime, except to the extent that

action had been taken in reliance on this authorization for the purposed stated above.

_____ _____ _____

Signature of Patient or Legal Rep Relationship to Patient Date