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/ Monica Smith, CPNP**
4405 Holland Sylvania Suite 104
Toledo, Ohio 43623
Fax: (419) 882-4795

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

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

Complete health record to be disclosed . Or check appropriate boxes.

History and Physical	Progress Notes	Discharge Summary	X-rays/Ultrasounds
Laboratory Testing	Consultations		

I understand that specific information to be released may include AIDS or HIV, Alcohol and/or drug abuse, and mental health records.

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 ninety (90) 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