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MEDICAL RECORD RELEASE AUTHORIZATION

Patient Name _____ Date of Birth _____

Address _____ City/State/Zip _____

Home # _____ Cell/Work # _____ Email Address _____

I hereby authorize records FROM or to be released to:

Alan R. Malouf, M.D., F.A.C.S. **– OR --**

Name_____

Address_____

City/State/Zip_____

Phone#_____

Fax#_____

For the purpose of: _____

Records Format: Please indicate how you would like to receive your records. ***(Subject to Fees)***

_____printed copies - will pick up
_____printed copies - sent by mail
_____secure fax (not to exceed 25 pages)

This authorization is valid for: _____Any and all medical records past and present

_____Medical records from _____to_____

I understand that the information in my medical record may include information relating to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Custodian of Records. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. This authorization will expire one year from the date below unless I specify an expiration date.

_____ _____

Date **Signature of Patient/Parent/Guardian or Authorized Representative**