Authorization for Medical Records Request/ Release

- Patient Name:_____
- Date of Birth: _____/_____/_____

You are hereby authorized to release/request any medical notes, reports, labs, operative reports and films to/from Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Mohammad Hojjati MD PhD, Dr. Khaled Albasha MD FACC, Sharolyn McClurg MSN CNP, Lauren Woffinden MSN ANP.

(FOR OFFICE TO FILL OUT)

We specifically request:_____

_____

_____

I hereby release Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Mohammad Hojjati MD PhD, Dr. Khaled Albasha MD FACC, Sharolyn McClurg MSN CNP, Lauren Woffinden MSN ANP and its staff from liability and all claims of nature whatsoever, pertaining to disclosure of this information.

If I have requested these records for my own personal use, I am responsible for the safe keeping of these records. Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Mohammad Hojjati MD PhD, Dr. Khaled Albasha MD FACC, Sharolyn McClurg MSN CNP, Lauren Woffinden MSN ANP and its staff is not responsible if these records were to get damaged or last once given to me.

- _____

  Patient Signature/Personal Representative Signature

(FOR OFFICE TO FILL OUT)

Dr. Name:_____

Phone Number:_____

Fax Number:_____