AUTHORIZATION FOR MEDICAL RECORDS REQUEST/
RELEASE OF RECORDS

- PATIENT NAME: _____
- DOB:_____

You are hereby authorized to release/receive any medical notes, reports, labs, operative reports and films to/from Zaki Lababidi MD, FACC, Khaled Albasha, MD, Sharolyn McClurg, MSN, NP-C, and Lindsey Estes, PA-C.

We specifically request: (FOR OFFICE TO FILL OUT)

_____

_____

_____

I hereby release Zaki Lababidi, MD, FACC, Khaled Albasha, MD, FACC, Sharolyn McClurg, MSN, NP-C, Lindsey Estes, PA-C, 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. Zaki Lababidi, MD, FACC, Khaled Albasha, MD, FACC, Sharolyn McClurg, MSN, NP-C, Lindsey Estes, PA-C and its staff are not responsible if these records were to get damaged or lost once given to me.

- _____
  Patient Signature/Personal Representative Signature

(FOR OFFICE TO FILL OUT)

Dr Name: _____

Phone Number: _____

Fax Number: _____

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3505 S. Mercy Rd
Gilbert, AZ 85297
Phone: (480) 786-9100
Fax: (480) 786-0742