Dr. Walid Elkhalili
6-20 Plaza Road
Fair Lawn, NJ 07410
Phone Number: 201-797-2003 Fax Number: 201-797-7003

Authorization for the Release of Medical Records

Patient's Name: _____ **DOB:** _____

Home Address: _____

Phone Number: _____ **Social Security:** _____-_____-_____

I _____ hereby authorize _____ to release my medical information for the purpose of _____.

Released to:

Dr./Facility Name: _____

Phone #: _____ **Fax #:** _____

To Be Picked Up: _____ **Faxed:** _____ **Mailed:** _____

Unless otherwise revoked by me, this authorization is valid for 3 months from the date above. Revocation MUST be made in writing. Revocation may not be made if action has already been taken in this authorization.

I understand that once _____ disclosed my health information to the Recipient in accordance with the terms and conditions of this authorization _____ cannot guarantee that Recipient will not disclose my health information to a third party.

I have read and understood the terms of this Authorization. I have had an opportunity to ask about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the release of my health information in the manner described above.

**** PROCESSING TIME WIL VARY DUE TO STATUS OF THE RECORD****

Patient Signature: _____ **Date:** _____

Legal Guardian Signature: _____