**Hesham Fakhri, MD**

2605 W. Swann Avenue
Suite 100
Tampa, Florida 33609
Phone :(813) 708-8346 Fax: (866) 270-9831

## Authorization for Release of Confidential Patient Health Information

**Patient Name: ___________________________________ Date of Birth: ___________**

**Maiden Name or other name (if applicable): _________________________________**

**Social Security Number: ________________________**

**Please do not leave any fields blank. Complete one (1) form per request.**

Name of physician (PCP) or practice: ___________________________
Phone: ______________

Address: ____________________________________ Fax: _________________

____________________________________

**Please check each item authorized for release:**

____ Hospital Records
____ Medication History
____ Consultation Reports (specify): ______________________________________
____ Laboratory Reports (specify): _______________________________________
____ Other (specify): ___________________________________________________

____ All Records - Complete medical records for past two years

This authorization will expire sixty (60) days from the date signed. I understand that I may revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance thereon.

_____________________________________________ ________________
Printed Name of Patient/Authorized Representative
Date

________________________________________
Signature (Patient/Authorized Representative)

Signature (Patient/Authorized Representative)