



RECORDS RELEASE FORM

From: _____

Address: _____

I hereby authorize and request the release of copies of the following information:

- Complete
 Medical Records
 X-Rays
 Laboratory Records
 Procedure Reports
 Other: _____

INCLUDING CURRENT AND PREVIOUS MEDICAL RECORDS FROM OTHER PRACTICES AND PRACTITIONERS, HOSPITALS, AND/OR CLINIC WHICH ARE A PART OF MY MEDICAL RECORDS.

To: Lamia L. Gabal-Shehab, MD, 16300 Sand Canyon Ave, Ste 405, Irvine, Ca 92618

Phone: 949.825.7650 Fax: 949.825.7648

This information has been released to you specifically with the consent of the patient or his/her authorized representative. It is strictly confidential and no further release or use of the information is authorized without the consent of the patient or authorized representative. I hereby release the facility from any Liability which may arise as a result of the use of the information contained in the records released.

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Phone #: _____

Signature: _____ Date: _____

- Single Disclosure
 Continuing disclosure for 90 days
 Expiration Date: _____