AUTHORIZATION TO RELEASE RECORDS

PATIENT'S NAME _____ DOB_____

I HEREBY AUTHORIZE: ***Grace Zlaket-Matta M.D, F.A.C.E.***
Iyad Syoufi, MD
9336 E. Raintree Dr., Ste 150
Scottsdale, AZ 85260
Phone: 480-219-5597
Fax 480-219-5547

PURPOSE OF RELEASE

APPOINTMENT/CONTINUATION OF CARE *DATE: _____*

MEDICAL RECORDS: _____ *DATE: _____*

SPECIFIC RECORDS: _____ *DATE: _____*

RADIOLOGY REPORTS: _____ *DATE: _____*

OTHER: _____ *DATE: _____*

TO RELEASE MEDICAL RECORDS INFORMATION CONCERNING THE ABOVE MENTIONED PATIENTS TO:

Name of Facility or Doctor_____

Address: _____

Phone #_____

Fax #_____

This consent will expire 60 days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify them in writing to that effect. I understand that any release which wasn't made prior to my revocation in compliance with his authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original and the information released may be subject to re-disclosure by the recipient and no longer protected by the privacy rule.

_____ _____
Patient Signature Date

_____ _____
Parent/Legally Authorized Representative Relationship to Patient