Regal Pediatrics
Dr. Mahmoud Elghoroury, MD
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient name: _____ Date of Birth: _____

Information about you cannot be exchanged without your consent. Your signature on this release authorizes your provider to obtain or release medical records or information regarding you or your child's care. For the purposes hereof, "Medical Records" include all confidential HIV-related information, confidential communicable disease-related information, confidential alcohol or drug-abuse related information, and confidential psychological, behavioral health, medical, and educational data.

This disclosure is for the purpose of diagnosis, treatment planning, follow-up, subpoena for records, coordination of care, employment, and/or any reason listed below:

_____

☐ Please **release** information **to**:

_____
Office/Doctor Name

_____
Address

_____
City, State, & Zip Code

_____
Phone Number

_____
Fax Number

☐ Please **release** information **from**:

_____
Office/Doctor Name

_____
Address

_____
City, State, & Zip Code

_____
Phone Number

_____
Fax Number

Include Date(s) of Service: _____

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Any disclosure of medical record information by the recipients is not authorized except when implicit in the purposes of this disclosure.

Relationship to patient:

☐ Parent/Legal Guardian

☐ Self

☐ Authorized Personnel

_____
Print Name

_____ _____
Signature Date