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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

According to HIPAA regulations, signed authorization is required before any medical information can be disclosed to anyone other than the patient.

Please be advised that the undersigned patient grants permission for his or her medical information to be discussed with the individuals listed below.

Patient Name: _____

Date of Birth: _____

I hereby authorize Moukdad Medical to discuss and/or release information regarding my medical care, test results, treatment, and billing with the following individual(s):

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

This authorization remains in effect until revoked in writing by the patient. I understand that I may revoke this authorization at any time by submitting a written notice to Moukdad Medical.

I understand that this authorization is voluntary and that treatment, payment or eligibility for benefits will not be conditioned on my decision to sign this form.

Patient Signature: _____ **Date:** _____

Witness / Staff Signature: _____ **Date:** _____