Sheikh Medical Care PLLC

103-02 93RD ST, OZONE PARK, NY New York 11417
Tel: 718-487-3944, Fax: 718-487-3929,
E-mail: sheikhmedicalcarepllc@gmail.com

AUTHORIZATION FOR RELEASE OF ALL MEDICAL RECORDS

(PLEASE TYPE OR PPRINT)

Patient's Full Name: _____

Social Security Number: _____ Date of Birth: _____

Physician who you're requesting specific records from:

Physician Name: _____

Physician Phone: _____

Physician Address: _____ Physician Fax: _____

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I'm requesting that my whole medical record be effectively released to continue medical treatment. I completely understand that our authorization efficiently authorizes the release of comprehensive medical records included. Keep in mind that these records aren't limited to records concerning Alcohol, Drug Abuse, or Psychiatric Abuse, as well as communicable diseases like Acquired Immune Deficiency Syndrome and/or Human Immunodeficiency Virus.

All the information provided will be legit and confidential. Moreover, any kind of re-disclosure by the specific recipient is strictly prohibited without written authorization. Records requested must be released within a month from receipt of this specific release. And, this consent to release highly confidential information can also be repealed by me at any time in writing, excluding the extent that the action has been already taken. No more/further information may be released anyway without the implementation of an exceptionally written authorization statement.

I also understand that such records are inclusively protected under state and federal law & can't be revealed without my consent. Having read the above information, I hereby release, hold innocuous, and agree not to prosecute my practice, its staff, agents, and employees in connection with the main disclosure of information set out related to these all-around medical records

Patient's Signature: _____ Date: _____

Parent or Legal Guardian: _____ Date: _____