SAED J. SAHOURI, M.D., PLLC

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Important: All blanks MUST be filled in)

Patient Name:_____ Birth Date:_____
Address:_____ SS#:_____
_____ Phone: ( )_____

Released FROM:_____ Released TO: **Saed J. Sahouri, M.D.**
_____ **1020 Charter Dr., Suite D**
_____ **Flint, MI 48532**
_____ **(810) 720-4200, Fax: 720-2711**

Specific type of information to be disclosed: _____Any and All Records _____Chart Notes Only
_____Diagnostic Reports Only _____Laboratory Results Only _____Consultations Only
_____Immunizations _____Other:_____ Time Period:_____

Records may include:

1) Information about communicable diseases and infections as defined by statute and Michigan Department of Health Rules (which include venereal diseases "VD," tuberculosis "TB," hepatitis B, human immunodeficiency virus "HIV," acquired immunodeficiency syndrome "AIDS," and AIDS related complex "ARC").
2) Alcohol and/or drug abuse treatment information protected under regulations in 42 Code of Federal Regulations, Part 2.
3) Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.

The purpose and need for such release: _____Transfer of Care _____Attorney Request
_____Worker's Comp. _____Disability _____Insurance _____Social Security
_____Consultant _____Personal _____Other:_____

- I understand, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.
- I understand that I have the right to refuse to sign this authorization or to inspect (or copy) my protected health information to be used or disclosed as permitted under federal and state laws.
- I understand the Practice will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. Further, if the practice will receive payment for obtaining this information, I understand I will be notified of the same.
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- Without express written revocation, this consent expires after one (1) year.

_____ _____
Patient (Guardian) Signature (Relationship) Printed Name

Dated: _____