MASSOUD SABERINIA MD
Endocrinology & Metabolism
Clinical Asst. Professor of Medicine Georgetown University

AUTHORIZATION FO RELEASE OF MEDICAL RECORDS

_____ _____
(Print patients full name) (Date of Birth)

_____ _____
(Street Address) (SSS#)

_____ _____
(City, State, Zip Code) (Main Phone Number)

I,_____ do hereby authorize Dr. Massoud
(Patient's Name)
Saberinia to release my medical records to:

Facility Name _____

Address _____

Phone Number _____

Fax Number _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for **ONE** time from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of individual or guardian of patient Date

******NOTE*: There will be a charge for a personal copy or the permanent transfer of your records.**