MEDICAL RECORDS RELEASE FORM

THIS AUTHORIZATION WILL NOT BE ACCEPTED UNLESS ALL ITEMS ARE COMPLETED.

The information being disclosed may include sensitive medical and mental health data.
This document authorizes the release of information entered into my medical record prior to or within 12 months after the date of my signature.

Please provide the format of medical records information requested by checking the boxes.

Patient Name		**DOB**
Request for	☐ Laboratory Test Results ☐ Medical Records	
	☐ Collection via pick up ☐ Sent via email	
Should you require your records to be emailed to you, the only option available is for records going directly to the patient or legal guardian of a minor.		
Additional dependents:		
Patient's Name		DOB
Patient's Name		DOB
Patient's Name		DOB
Patient's Name		DOB

In my absence, I, _____, authorize _____, to collect my medical records on my behalf.

Patient's Signature	Doctor's Signature

I hereby release the provider of said records from any legal responsibility in connection with the release of the records indicated herein.

If you have requested that your records are sent to you via email, please note these files are not encrypted and therefore we cannot guarantee confidentiality.

Please either drop off the form, fax (04 343 6687) or email (admin@ihcdubai.com) it back to the clinic.

Received by:	Date: