



AUTHORIZATION FOR MEDICAL RECORDS RELEASE

Patient Name: \_\_\_\_\_  
Previous Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

By signing this form, I hereby authorize \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

to disclose the health information described below to (fax, email or CD is always preferred to paper!) Naureen A. Mohamed, MD 5820 Main Street, Suite 314, Williamsville, NY 14221, phone 716-633-3323, fax 716-633-3323, email- [docmohamed@onebox.com](mailto:docmohamed@onebox.com) (secure). Get a free secure email box for health related purposes at [www.docmohamed.com](http://www.docmohamed.com).

Check all that apply:  
 all health information  
 health information relating to the following treatment or condition: \_\_\_\_\_  
 health information for the date(s)  
 other specific description

Reason for this authorization  
 at my request  
 other(specify) \_\_\_\_\_

This authorization expires upon: \_\_\_\_\_

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing and authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party and that if I refuse to sign an authorization those services may be denied. I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested, to the privacy officer at the health care provider listed above. Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

Date: \_\_\_\_\_

Signature of patient or legal representative: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_