WISSAM KHOORY, M.D., P.C.

20 Hope Avenue, S. G03 Waltham, MA 02453

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: _____
_____
_____

Patient Name: _____ Date of Birth: _____
Address: _____
_____
Telephone: _____

Release Information to:

Wissam Khoory, M.D.
20 Hope Avenue, S. G03
Waltham, MA 02453

Information to be Released (check all that apply)

___ Office Notes ___ Lab Reports ___ X-ray Reports
___ Complete Chart ___ Operative Reports ___ Discharge Summary
___ Other: _____

Authorization remains valid for1 year from date of signature.

Patient Signature _____ **Date** _____
Parent/Guardian _____ **Date** _____

****

Authorization for Release of Sensitive Information

This medical record may contain certain sensitive or statutorily protected information. Please indicate the information you would like released. A separate signature is required.

___ Mental Health Information ___ Social Service Information
___ Domestic Violence Information ___ Sexual Assault Information
___ Alcohol/Drug Abuse Information ___ Sexual Transmitted Diseases
___ HIV Testing ___ Aids Treatment

Patient Signature: _____ **Date:** _____
Parent/Guardian: _____ **Date:** _____