Sammy Zakhary M.D., P.C.
Valley Vein and Vascular Surgeons
6591 W Thunderbird Rd Suite D2
Glendale, Arizona 85306

MEDICAL RECORDS RELEASE

Patient Name:_____ Date:_____

I authorize the office of _____to release all medical records information concerning the above named patient to Sammy Zakhary, M.D., P.C.

AND/OR

I authorize the office of Sammy Zakhary, M.D., P.C., to release all medical records information to the following:_____
_____

This release is valid for one year unless revoked by the patient in writing.

Please read the following statement carefully prior to signing this release of information:

I hereby release you, your physician, and or employees from any and all liability for fulfilling the authorization request for release of medical information. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify you in writing to that effect. I understand that any releases, which were made prior to my revocation in compliance with this authorization, shall not constitute a breach of my right confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

Patient Signature: _____ Date: _____

Guardian/POA: _____ Relationship to Patient:_____