Mais Arwani, M.D.
Radwan Asaad, M.D., F.A.C.O.G.
M.O. Bayram, M.D., F.A.C.O.G.
Danny Benjamin, M.D., F.A.C.O.G.
Cathy Clubb, M.D., F.A.C.O.G.
Vicki Kean, D.O.
Yuliya Malayev, D.O.

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: ______________________________________DOB: _______________

Address:____

____

Phone:_______________________________

I hereby request that my medical records be released: ☐ **To** (or) ☐ **From**
(check appropriate box)

☐ Mais Arwani, M.D. ☐ Radwan Asaad, MD ☐ M.O. Bayram, MD ☐ Danny Benjamin, MD

☐ Cathy Clubb, MD ☐ Vicki Kean, DO ☐ Yuliya Malayev, DO

☐ **To** (or) ☐ **From** Name: ____

Address: ____

City/State/Zip: ______________________________________

Phone: __________________ Fax: _____________________

Metro Obstetrics and Gynecology is authorized to release my health care information relating to the following treatment, conditions, or dates of treatment that they provided: (i.e. all records, recent tests, results [specify], etc.)

____

Please list reason for transfer: (i.e. moving, insurance change, transfer of care, etc.)

____

I understand health records in my file obtained from other health care entities may not be included in this request. I understand that my express consent is required to release any health care information related to testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug/alcohol use, you are specifically authorized to release all health information related to such diagnosis, testing, or treatment.

____ ____________________
Signature of Patient or Authorized Representative Date Signed

____
Relationship to Patient, if not Patient

24 Hour Answering Service
248-522-2828