AUTHORIZATION FOR RELEASE OF INFORMATION
(For Record Release from Sinai Clinic Hospital)

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider,. I understand that my health care will not be affected if I do not sign this form.

Patient Name: **Patient Address:**	**Date of Birth:** **SS** **Number:**
Persons/organizations providing the information: **Address :** 2B. Banks St. Hadaba, Sharm El Sheikh, South Sinai, Egypt	**Persons/organizations receiving the information:**
Telephone Numbers : +2 069 3666850 +2 069 3666851 +2 069 3666852 +2 012 81999938	**E-Mail :** medical.records@sinaiclinichospital.com **Fax :** +2 069 3666854

Specific description of information *Requestor will be charged in accordance with New York State Laws.*

Abstract (all dictated notes, face sheets, lab, X-rays, EKGs)	Discharge Summary	Radiology Records
History & Physical	Entire Emergency Record	Labs
Progress Notes	Operative Note	Doctor's Orders
Consultation	Pathology Records	Nurses Notes
	Anesthesia Record	

Other:_____ **Type of access requested:** Inspection_____ Copies_____

Date(s) of Hospitalization Requested:

1. What is the purpose of the use or disclosure?

2. I understand that this authorization will expire on ___/___/___ or upon compliance with the request for information, whichever occurs first. **Initials**:

3. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, But if I do, it won't have any effect on any actions they took before they received the revocation. **Initials**:

Drug, Alcohol, and Psychiatric Exclusion

Check this box ONLY if you do not consent to the release of drug, alcohol, and/or psychiatric information.

Initials:

Signature Date

Relationship, if not patient:_____

Notary Public/AOMC Witness Date

To be Completed by AOMC Staff – Date Completed:_____ Initials:_____

MR #: Number of Pages Sent:_ Mailed Faxed Hand Delivered