HEALTH First
MEDICAL CENTER
Syed F. Hussain M.D.

CONSENT TO RELEASE MEDICAL RECORDS

Patient Name_____

Date of Birth _____/_____/_____ SS# _____-_____-_____

Address_____

City_____ State_____ Zip_____

I_____, hereby authorize the release of my medical records to records to:

_____
Facility or Physicians Name

Address_____

City_____ State_____ Zip_____

Phone_____ Fax_____

_____ Date ____/____/____
Signature