

MIDWEST FAMILY MEDICINE
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RECORD RELEASE AUTHORIZATION

TO: _____

ADDRESS: _____

I HEREBY AUTHORIZE AND REQUEST THAT YOU RELEASE MY RECORDS AS INDICATED BELOW:

SAM AWADA, M.D.

THE COMPLETE HISTORY OF RECORDS, INCLUDING, BUT NOT LIMITED TO X-RAYS, PROGRESS NOTES, LABS, AND EKGS FOR THE FOLLOWING PERIOD:

START DATE: _____ THROUGH _____

PATIENT NAME: _____

ADDRESS: _____

SIGNATURE: _____ DATE: _____

GUARDIAN/PARENT IF UNDER 18: _____

WITNESS: _____ DATE: _____

THE ABOVE INFORMATION IS TO BE USED IN COMPLIANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996.