

**MALEK MEDICAL CENTER**  
**Dr. Sherif Malek**  
**232 Norwood Avenue, W.L.B. NJ 07764**  
**Tel# (732)222-6637 Fax# (732)222-6645**

**MEDICAL RECORDS RELEASE AUTHORIZATION**

**Patient's name:** \_\_\_\_\_

**D.O.B.** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Attn:** \_\_\_\_\_

I hereby authorize and request the release of:

\_\_\_My complete medical history records in your possession concerning my illnesses and/ or treatment.

\_\_\_The specified reports indicated: \_\_\_\_\_

**Please release it to:**

**Dr. Sherif Malek**  
**232 Norwood Avenue,**  
**West Long Branch, N.J. 07764**

I understand that I have the right to revoke this Authorization anytime. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and or/copy the information to be disclosed. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics.

**Signature of patient or authorized Representative:** \_\_\_\_\_

**Description of Representative's authority:** \_\_\_\_\_

**Date:** \_\_\_\_\_