



AUTHORIZATION FOR RELEASE OF INFORMATION

SAMY M. SHAROBEEH, MD.

Patient Name: _____

Date of Birth: _____

I hereby authorize Samy Sharobeem, MD. to **disclose** my protected health information to:

I hereby authorize Samy Sharobeem, MD. to **obtain** my protected health information from:

Release is authorized for the following specific purpose(s) or activity (Please Circle):

A) Medical Care/Legal B) Insurance/Personal C) Other Use: _____

Authorization covers (Please circle): A) Entire Period of Care B) Past _____ years of treatment

Authorization covers the release of sensitive, protected information regarding Sexually transmitted disease results (Please circle): YES NO

RELEASE OF HIV/AIDS and/or GENETIC INFORMATION (required for each release)

HIV/AIDS Testing and Treatment (Please circle): YES NO

I hereby authorize release of protected health information pertaining to HIV testing and/or diagnosis and/or treatment of acquired Immune Deficiency Syndrome (AIDS) solely to the person or organization described above and solely for the purpose stated above.

Genetics Testing (Please circle): YES NO

I hereby authorize release of protected health information pertaining to genetic test results to the person or organization Described above and solely for the purpose stated above.

Signature of patient or authorized representative

Date

I understand that information used or disclosed as a result of this Authorization may be further used or disclosed by someone who obtains such information and therefore may no longer be protected by federal privacy laws. Except to the extent allowed by law, Samy Sharobeem, M.D., will not condition treatment on my signing this authorization. I acknowledge that I have signed this Authorization voluntarily.

I also understand that I have the right to revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it. To revoke this Authorization, please complete our Authorization Revocation form and leave it with the front desk or mail it to our office.

This Authorization expires on: _____ (or if unspecified, 180 days from the date of signature)

Signature of Patient or Patient Representative: _____ **Date:** _____