PLEASE INCLUDE THIS WITH THE MEDICAL RECORDS.

Medical Records Release Form

I, the undersigned, authorize _____ to release information from my medical records. This authorization includes the release of information concerning treatment of psychiatric/psychological condition, drug and/or alcohol related conditions and HIV/AIDs related conditions. Please release the following information:

***Operative note and pathology report from a tubal sterilization performed on the appproximated date of: _____**

I would appreciate having these records faxed to Dr. Sameh Toma at 919-233-1685 (Tubal Reversal Patients Attn: Llissel) or mailed to his office at:

NCCRM
Attn: Tubal Reversal Department
400-200 Ashville Ave.
Cary, NC 27518

This authorization must be signed and dated, and may be revoked at any time except to the extent action has been taken prior to revocation. Revocation must be made in writing. This authorization will expire on _____. I hereby state that I have read and fully understand the above statements as they apply to me. I acknowledge that I understand treatment, payment, enrollment in any health plan, or eligibility for benefits are not conditioned on signing this authorization. I hereby authorize to the disclosure of the medical records to the purpose and extent stated above.

Medical Records Name: _____

Current Name: _____

Date of Birth: _____

Home Phone: _____

Email Address: _____

Signature: _____ Date: _____

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