



Ziyad H. Mugharbil, MD

Urology Practice

Office: 828/837-7513

Toll Free: 888/837-7513

Fax: 828/837-2912

4188 US Highway 64 East, Suite 6
Murphy, NC 28906

47 Weaver Road, Suite B
Blairsville, GA 30512

www.drmmugharbil.org

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

| | |
|------------------------------------|----------------------------|
| | |
| Patient Last Name, First Name , MI | Date of Birth (mm-dd-yyyy) |

| | |
|---------------------|--|
| Sending Institution | |
| Address | |
| City, State, Zip | |
| Fax if Applicable | |

I, request and authorize the disclosure of my protected health information to Ziyad H. Mugharbil, MD, PA at the address listed above.

The purpose of this disclosure is for enclosure and accuracy of my medical history.

I specifically request and authorize release of all information regarding services rendered to me from (dates) _____ to _____. Such information is to include History and Physical, Medication Lists, Results of Diagnostic Testing, Operative, therapy and procedure records and Discharge summaries.

In addition: I authorize the disclosure of information contained in the highly confidential categories as indicated by my initials on the applicable line(s) below.

_____ Mental Health or Developmental Disabilities _____ HIV/AIDS Testing or Treatment

_____ Substance Abuse (Drug & Alcohol) _____ Sexually Transmitted Diseases.

I understand that acknowledge that I am voluntarily signing this authorization and that the information that is released will no longer be protected under the federal privacy laws. I understand that this authorization will expire one year from the date of signing unless revoked earlier by me in writing and can not be withdrawn after the disclosure.

I hereby authorize that a photocopy of this request shall be considered as valid as the original.

Patient/Guardian/POA Printed Signature

____/____/____
Date

Patient/Guardian/POA Printed Name

Witness Signature

____/____/____
Date

Witness Printed Name