MEDICAL RECORDS TRANSFER RELEASE

Date: _____

To: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Patient Information:

Name: _____

Date of Birth: _____ SSN: _____

Address: _____

_____

Telephone Number: _____

Date(s) of Treatment: _____ - _____

I hereby authorize the release of my _____ (medical records and/or lab reports) or copies of such and request that they are transferred to:

Ayad Alsaadi, M.D.
10721 Main Street, Suite 2100
Fairfax, VA 22030
Tel: (703) 802-6700
Fax: (703) 802-6701

_____ _____
Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date