LIVE WELL NEUROLOGY AND SLEEP
Nadia F. Zaki MD

Medical Records Release Request

I, _____, authorize _____

Address: _____ Phone _____ Fax_____

To release a copy of my medical records as specified below for coordination of clinical services and care, also for claim determination for insurance payments if needed.

I authorize the release of my medical records to Nadia Zaki, MD, located at 725 Barclay Circle Suite 220 Rochester Hills, MI 48307 Phone (248) 289-6778 Fax (248) 289-6978.

- ☐ The medical record in its entirety.
- ☐ Specific dates within the record from _____ to _____.
- ☐ Diagnostic Imaging (MRI, MRA, CT, EEG, EMG, ENG, TCD SEP, VEP)
- ☐ Progress Notes (for dates indicated)
- ☐ Hospital Admissions and discharge summaries
- ☐ Hospital Notes
- ☐ Operative notes, reports and their findings

These records may also include:

- ○ Alcohol and drug abuse information.
- ○ Psychological Evaluations and services
- ○ Information regarding HIV, AIDS, or any communicable disease. _____ patients Initials

_____ _____

Signature of Patient or Patient Representative Date

Patients Date of Birth _____

_____ _____

Witness (Office Employee) Date