David E. Simai, M.D.

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CONSENT ACCESS AND RELEASE INFORMATION

I, _____ hereby grant the release of medical records of:
(Please Print)
Name of Patient(s):_____
Address: _____
Phone Number: _____
Date (s) of Birth: _____
For the Purpose of: _____

Please check if you want to release medical records **TO** Dr. Simai's office **OR** if you would like Dr. Simai to release the records to another provider.

☐ Release medical records to Dr. Simai

Name of previous doctor: _____
Phone number: _____
Fax number: _____

☐ Release medical Records from Dr. Simai to:

_____
_____
_____
Specific Information to be Released: _____

This release shall relieve Dr. Simai from any liability which may result from use of this information. Photocopies of this release shall be valid as the original.
I, the undersigned, understand that I may revoke this authorization of release of medical records at any time, except to the extent actions has been taken in reliance on it and that in any event this authorization shall expire 90 days from when it is signed unless another date is specified below. I authorize _____ to release information regarding treatment. I understand that the information may include psychological or psychiatric impairment, drug abuse, alcoholism, infections or contagious disease information.

I hereby state that my request to transfer to Dr. Simai's office is solely based on my own wishes; I have not been solicited by Dr. Simai or any of his staff members.

Signature: _____ Witness: _____

Date: _____ Date: _____
Relationship to patient: _____ Title: _____