

RECORDS RELEASE AUTHORIZATION

TO: \_\_\_\_\_

I, \_\_\_\_\_

DOB: \_\_\_\_\_

HEREBY REQUEST THAT YOU RELEASE TO :

DR. SALLY HABIB, MD, LLC.  
INTERNAL MEDICINE  
120 SISTER PIERRE DRIVE, SUITE 306  
TOWSON , MD 21204

PH: 410-823-0358  
FAX:410-823-8381

A COPY OF MY MEDICAL RECORDS FROM:  
\_\_\_\_\_ TO \_\_\_\_\_

- PLEASE INCLUDE :
- HISTORY & PHYSICAL  LAB DATA  COLONOSCOPY REPORT
  - MAMMOGRAM  DEXA  IMMUNIZATION RECORDS
  - CONSULT NOTES  IMAGING STUDIES  DISCHARGE SUMMARY

DATE OF REQUEST: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE: \_\_\_\_\_