PATIENT RELEASE FORM

(a) I authorize the health care professionals who treat me through the Muslim Community Center Medical Clinic to discuss any and all patient information about me and my treatment, medical condition or related topics to visiting clinicians, healthcare professionals, and care-related vendors.

(b) I release the Muslim Community Center Medical Clinic from any and all state or federal statutes relating to patient privacy.

(c) I specifically authorize officials from the Muslim Community Center Medical Clinic to discuss my case (or my child's case, or an individual to whom I provide guardianship), with these individuals.

(d) Any release of original or copies of records will require my written authorization.

Date of Observation: ___________________________________

Affiliated individual (Choose from Drop Down Menu): ________________________

Name (Please Print): ____

Signature: ____

Parent/Guardian Signature for (Please Print): ____

Date: ____

Telephone number: ____

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