

## *Request for Release of Medical Records*

To:

**Dr. Marwan M. Shaykh, MD**  
**3627 University Blvd. S., Suite 450**  
**Jacksonville, FL 32216**  
**Phone: (904) 398-1473**  
**Fax: (904) 399-3436**

*I hereby request that my medical records be released to:*

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

*I understand these records contain information from other health care providers, as well as information which is administrative in nature. I specifically consent in the release of any information contained in the medical records which may relate to infection with Human Immunodeficiency Virus (HIV), AIDS or related conditions.*

*Patient Name*  
\_\_\_\_\_

*Date of Birth* \_\_\_\_\_ *Social Security Number* \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

*Patient Signature* \_\_\_\_\_ *Date*  
\_\_\_\_\_

**Please send the following information:**

\_\_\_\_\_ Send all my records

\_\_\_\_\_ Medical information, including physician notes/summaries and diagnostic results for the period from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ Other: Specify information to release \_\_\_\_\_

\_\_\_\_\_

**Thank you for your assistance.**