

NASSIM AND ASSOCIATES, PSC
2305 GREEN VALLEY ROAD
NEW ALBANY, INDIANA 47150
(812) 949-0405

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Nassim and Associates, PSC to send all pertinent medical information, test results, x-rays, correspondence and surgical records on the child/children listed below. Unless otherwise indicated, this authorization includes psychiatric, mental health, alcohol and/or drug abuse and any sexually transmitted disease information.

Information to be disclosed from: () Entire record () Specified portions
List portions: _____

PATIENT:

_____	DOB: _____
_____	DOB: _____
_____	DOB: _____
_____	DOB: _____
_____	DOB: _____

TO:

I understand by transferring the above records, I am requesting another physician to be in charge of my child/childrens healthcare.

If in the future you wish to return to this practice, please contact the office regarding the policy of such.

Signature: _____

Address: _____

Date: _____ Time: _____

Relationship to Patient: _____

Witness: _____