AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I,____, authorize the office of Dr. Stephanie Lim to release confidential medical records for______________________________, associated with the practice of Drs. Siham Zerhouni Abdouh and Zaheer S. Kanji Inc. I understand that I am responsible for maintaining the confidentiality of the printed medical records. I also understand that I am responsible for any administrative costs associated with the request for medical records.

☐ I request release of all medical records on file

☐ I request release of records from ___________20_____, till ____________20_______.

☐ I request release of specific records:____.

Please select surgeon:

☐ Dr. Zaheer S. Kanji

☐ Dr. Siham Zerhouni Abdouh

☐ Both

The request has been made on this date_________________________, 20_________, in the city

of_______________________________, in the province of_______________________________.

By signing below, I confirm that I have the authority to request and be in possession of the medical records requested above. If I am not the individual for whom records are being requested, I have provided appropriate legal documentation granting me the ability to request such records on their behalf. Dr. Lim's office will not be held liable for any requests granted which is later found to be on fraudulent grounds.

_________________________________.
Signature

__________________________________.
Print Name