

INTERNAL MEDICINE BOARD CERTIFIED

201 LONGWOOD DRIVE, SUITE B • HUNTSVILLE, AL 35801 PHONE (256) 536-9604 • FAX (256) 536-9606

RECORDS RELEASE AUTHORIZATION

I hereby authorize:					
to release my comple	te medical records	to:			
SAAD	AT H. ANS	SARI. M	.D.		
N1 11 12	PHYSICIAN			_	
	STREET				
CITY		STATE	ZIP		
I give my permission	to have reports an	d medical rec	ords faxed.		
	Patient Name				
	Date of Birth			_	
X					
<u> </u>	Patient Signature				Date
	Witness				Date