



Scott Zashin M.D.
We Understand. We're Here To Help!
RHEUMATOLOGY

(214) 363-2812
FAX (214) 692-8591

Medical Records Authorization For Release and/or Fax Transmission of Protected Health Information

Patient Name: _____

Address: _____

Date of Birth: _____ SS Number: _____

I authorize Dr. Scott Zashin to release the following medical information to the following persons including any doctors or personal contacts:

1) Name: _____

2) Name: _____

3) Name: _____

4) Name: _____

5) Name: _____

6) Name: _____

I understand that Dr. Zashin's staff may or may not be transmitting my medical records by fax.

You may at anytime revoke or terminate authorization by submitting a written revocation.

Patient's Signature: _____ Date: _____