Issam Nemeh, M.D., Inc. and I.N. & G.S. Inc.
AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION FROM OTHER HEALTHCARE FACILITIES

Name:__________________________ SSN#__________________________

CCF#__________________________ Date of Birth: ____ /____ /_________

Fax#__________________________ Address:__________________________

Telephone#__________________________ City:_______________ State: _____ Zip:__________

Reason for Disclosure____

Name of Healthcare Facility from which Records are Requested: __________________________

Address:__________________________

Street:__________________________

City:_______________ State_______ Zip:____

Dates of Treatment Requested:____

MAIL INFORMATION TO: OR E-MAIL INFORMATION TO:

Release Medical Information to: Issam Nemeh, M.D.., Inc.
Executive Club Office Bldg. West
21360 Center Ridge Road
Suite 401 **Medical Records**
Rocky River, Ohio 44116

Phone: 440-331-4700 Fax: 440 331 4757

www.drnemeh.com
medical records

Reason for Disclosure: ____

I hereby authorize Issam Nemeh, M.D., Inc. and I.N. & G.S., Inc. a scientific research company to obtain all of my medical records including records pertaining to treatment, prognosis and diagnosis, including any specially protected or listed records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection.

__________________________ __________________________ ___ /____ / ____
*Signature of Patients/Patient's Representative*** *Printed Name* *Date Signed*

____
Relationship if not Parent

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request. Exception: parent signing for a patient under the age of 18.*

Note: I.N. & G.S. Inc is a medical research company that Dr. Nemeh is utilizing to document healings.