



Mouhanad Freih MD FACC FSCAI
16392 Coastal Hwy Lewes, De 19958
Phone 302-703-9743
Fax 855-888-0359

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Date: _____.

Patient Name: _____ . Date of Birth: _____.

I hereby authorize the following Doctor to release medical information to the requesting provider.

Name: _____.

All Health Care Information.

Other. _____.

Patient Signature: _____ . Date: _____.