Ziyad H Mugharbil, MD

Urology Practice

NPI: 1124097118

Office: 828/837-7513

Toll Free: 888/837-7513

Fax: 828/837-2912

Mail all correspondence to:

4048 E US 64 ALT
Suite 6
Murphy, NC 28906

214 Hospital Circle
Out Patient
Blairsville, GA 30512

110 Main Street
Specialty Clinic
Hiawassee, GA 30546

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Dr. Mugharbil's office to disclose the following protected health information. I acknowledge that the information I am requesting may contain documentation of a confidential nature such as HIV/AIDS information, Substance (Drug/Alcohol) Abuse information, Psychiatric/Psychological information, as indicated by my signature below (if applicable).

☒ Office Notes ☒ Lab Results ☒ Reports ☒ Insurance Information ☒ Letters ☒ X-rays

Please send or fax this information to:

Name: _____

Address: _____

Fax #: _____

This protected health information is being used or disclosed to carry out treatment, payment and/or health are operations of Ziyad H. Mugharbil, MD.

This authorization shall be in force and effect for one year at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to, Privacy Officer, 4188 East US Highway 64, Suite 6, Murphy, NC 28906. I understand that a revocation is not effective to the extent that Dr. Mugharbil has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Dr. Mugharbil will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

_____ ____/____/____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Description of Personal Representatives' Authority

Revised: 01/03/2009