

**SUSAN YAHIA, D.O., F.A.C.O.I.**

DIPLOMATE, AMERICAN OSTEOPATHIC BOARD OF INTERNAL MEDICINE

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MIAMI, FLORIDA 33176  
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REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: \_\_\_\_\_ DATE: \_\_\_\_\_

FAX/ADDRESS: \_\_\_\_\_

NAME OF PATIENT: \_\_\_\_\_ DOB: \_\_\_\_\_

ITEMS REQUESTED: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please release my medical records and information regarding my treatment, hospitalization, and/or outpatient care for my condition, including, but not limited to, psychological or psychiatric impairment, drug abuse, and or alcoholism, sickle cell anemia, AIDS (Acquired Immune Deficiency Syndrome), AIDS-related complex (ARC) and HIV antibody testing to:

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MIAMI, FL 33176  
(305)271-0878 phone  
(305)271-8618 fax  
SUSAN@DOCTORYAHIA.COM

Signature \_\_\_\_\_ DATE: \_\_\_\_\_