Abdul Khalid, MD, P.A.

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____Date of Birth_____

I hereby authorize Abdul Khalid, MD, P.A., to _____ Release _____Obtain

Specific information in my medical/patient/educational record for the purpose of continued medical care

_____

(Individual, Facility, or Organization)

_____

Address

_____ _____

Phone number Fax number

Information to be used or disclosed include the available items checked below:

-------Hospitalization	-------Consultation Report	------Discharge Summary
------Initial Evaluation	-------History & Physical	------Treatment Notes
------Psychological Testing	-------Labs	------Other_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation form.* I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given. I further understand that I may request a copy of this signed authorization.

_____ _____

Patient's Name Date