AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient Name: ________________________ **DOB:** ______________ **Phone:** __________________

Persons Authorized to Use or Disclose Information (check all that apply): ☐ **(Name of Provider):**____________________ **Address:** ______________________________	**Information May be release via (Check all that apply):** ☐ Phone ☐ Email ☐ Fax ☐ Mail
Person (circle which) to / from Whom Information May be Disclosed: **Name:**____ **Address:**______________________________________ **City, State:**_________________**Zip:**_______________ **Phone:**_____________________**Fax:**_______________ **Email:**_______________________________________	**Expiration Date of Termination:** **This Authorization is effective through:** ______________/_______________/___________ **Unless revoked earlier by the patient or the patient's personal representative.**

INFORMATION TO BE USED OR DISCLOSED TO:

☐ Entire Record ☐ Medication Record ☐ Lab Results ☐ Treatment Plan
☐ Initial Eval ☐ Radiology Results ☐ Auth History ☐ Other: _________
☐ **ALL DATES** ☐ **FROM DATE:**____________**TO DATE:** ____________

I also give special permission to release any information regarding items listed below (Initial):

☐ **Psychiatric:** _________ ☐ **HIV Medical Info:** ______ ☐ **Substance Abuse:** _______

PURPOSE OF DISCLOSURE:

☐ Continuity of Care ☐ Patient/Guardian Request (Fee Applies) ☐ Disability Benefits (Fee Applies) ☐ Attorney Request (Fee Applies)
☐ Other (fee applies): ____

RIGHTS TO TERMINATE OR REVOKE AUTHORIZATION:

You may revoke or terminate this authorization by submitting a written revocation to Shanawar Alam, M.D.'s office. You should contact the office to terminate this authorization.

POTENTIAL FOR RE-DISCLOSURE:

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Shanawar Alam, M.D.'s office discloses it to another party.

RIGHTS OF THE INDIVIDUAL:

You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization.

EFFECTS OF REFUSING AUTHORIZATION:

If you refuse to sign this authorization, Shanawar Alam, M.D. will not deny you any treatment except research -related treatment or treatment that you have requested for the purpose of this disclosure to others, including treatment for enrollment, eligibility for benefits, etc.

____ ___________ ________________________________
Print Patient Name DOB Email

____ ____
Patient/Guardian Signature Guardian Name if applicable

____ ____
Witness Signature Date