Salman Ahmad, M.D., P.A.

2345 50th Street, Ste. 500 Lubbock, TX 79412 (o) 806-701-5797 (f) 806-701-5798

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This form **must** be completed in its entirety to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulation. If any field is left blank, the authorization will be considered void.

Patient's Name: _____ Date of Birth: _____ SS#: _____

Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

I authorized the following facility:
(releaser of records)

Medical Office: _____

Fax #: _____ Address: _____

City, State: _____ Zip: _____

To release the Personal Health Information indicated below:

____ Entire Medical Record ____ Hospital Records ____ Lab Reports ____ Pathology Reports

____ Diagnostic Imaging Reports ____ Progress Notes ____ Psychotherapy Notes ____ Billing Records

_____ **Last "2" Progress Notes, Labs, XRAYS** ____ Other: _____

To the office of:
(receiver of records)

SALMAN AHMAD, M.D., P.A.
2345 50th Street, Ste. 500
806-701-5798 **Lubbock, Texas 79412**

I hereby discharge the releasing and receiving facilities, its agents, and employees from all liabilities, responsibilities, damages, and claims, which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit. I understand further use or disclosure of the authorized information by the above-named agency/individual my not be accomplished without my further written authorization.

This authorization will automatically expire 60 days after the date below, unless an earlier date is specified, or after a specified event. I understand that I have a right to revoke this authorization at any time in writing, as stated in the Notice of Privacy Practices, except where the office has already made disclosures in reliance upon my prior authorization.

Patient's Signature: _____ Date: _____ Exp. Date: _____

Relationship to Patient: _____ Witness Signature: _____

****THERE WILL BE A CHARGE FOR COPYING MEDICAL RECORDS****