SAXON INTERNAL MEDICINE, P.A
SYED GHAZAL KHURSHID. M.D.
UZMA AHMED KHURSHID, M.D.
Diplomates of the American Board of Internal Medicine

AUTHORIZATION FOR TREATMENT / RELEASE OF PATIENT INFORMATION

Consent to Treatment: The patient and/or authorized representative do hereby consent to any and all medical treatment which may deem advisable by the physician(s) of Saxon Internal Medicine, P. A.

Authorization for Release of Confidential Information: I hereby authorize Saxon Internal Medicine, P. A. to release medical information contained in my/the patient's records to any insurance carrier, employer or other third-party intermediary utilized by the patients for the purpose of obtaining information and/or reviewing the record of medical care needed by the patient for the payment of all medical charges. Medical Records released may include any diagnostic or therapeutic information of visits and/or procedures performed in office.

Unless initialed below the records may not include any confidential information regarding:

Alcohol/Substance Abuse	**Mental Health**	**HIV**
_____	_____	_____

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

The patient's medical record may not be furnished to and the medical condition of the patient may not be discussed with any other person than the patient, the patient's legal representative, or other health care practitioners involved in the care and treatment of the patient without the patient's written authorization.

The patient may at this time authorize an individual to be actively involved in the patient information as mentioned above.

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ADVANCED CARE PLAN

If I cannot speak for myself, I would like my doctor to talk about my health care and medical problems to the following person/s: (please write their name and contact number/s):

Name	Phone Number	Relationship

Patient Signature: _____ **Date:** _____

Patient or Legal Guardians Printed Name: _____

Relationship to the patient: _____