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

PATIENT AUTHORIZATION FOR USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use of disclosure of my individual identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations.

Patient Name: _____ **DOB:** _____

Persons/organizations providing the information:

_____
_____
_____
_____

Person/organization receiving the information:

_____
_____
_____
_____

Please specify the information that you would like to be released (including date(s)):

_____
_____
_____
_____

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I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information that may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease, and all other sensitive information.

Patient Signature: _____ **Date:** _____

Patient or Legal Guardians Printed Name: _____

Relationship to the patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

You may not use this form to release information for treatment of payment except when the information to be released is psychotherapy notes or certain research information.