AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____

I hereby authorize:

Physician/ Medical Group: _____
Address: _____
Phone Number: _____ Fax Number: _____

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

TO: **Ahsan U. Rashid, M.D., F.A.C.P.**
113 Waterworks Way, Suite 250
Irvine, CA 92618
(949) 753-1522 Fax: (949) 753-6075

This authorization is:

[ ] Unlimited (all medical records)
[ ] Limited to the following medical information _____

This authorization is effective immediately and is subject to revocation at any time, except that action has already been taken. Otherwise, the authorization expires 90 days from the date of signing.

I understand that this is a required consent and that I must voluntarily and knowingly sign this authorization BEFORE any records can be released, and that I may refuse to sign.

In addition to the above records, I consent to release of records including those of:

Drug/ Alcohol/ Substance Abuse: _____ (initial)
Psychiatric/ Mental Health _____ (initial)
Tests for Antibodies to HIV _____ (initial)
AIDS diagnosis/ Treatment _____ (initial)

I understand that I have the right to receive a copy of this authorization upon my request.

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____

Relationship to Patient: _____