



Kashif Ahmed M.D.

528 Forest Parkway Suite A, Forest Park, Ga. 30297
Phone: 404-968-9469 | Fax: 404-968-9341

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I requested and authorize _____ to
Release healthcare information of the patient named above to:

Name: Ahmed Family Practice

Address: 528 Forest Parkway Suite A

City: Forest Park State: GA Zip Code: 30297

This request and authorization applies to:

Healthcare Information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma vanereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED