Gaffar Syed, M.D., P.A.
Board Certified Internal Medicine
P(301)698-9444 F(301)695-4444

HIPPA Privacy and Release of Information Authorization

Patient Name: ____________________
Patient DOB: ____________________

I, _____________________, hereby authorize Gaffar Syed, MD and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to Gaffar Syed, MD. However, this authorization may NOT be revoked if, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice’s Privacy Policies, Release of Billing Information, Assignment of Benefits Policy, and grant the practice Medication History Authorization.

By signing this form, I represent that I am the legal representative of the member identified above and will provide written proof that I am legally authorized to act on the member’s behalf with respect to this authorization form.

I authorize the below listed individual(s) to access my medical record and Protected Health Information(PHI).

Name_________________ Phone Number___________________ Relationship____________

Patient Printed Name   Patient Signature   Date