CHANDLER NEUROLOGY & SLEEP DISORDERS
Medical Record Release

Name:_____ DOB:_____ Phone: _____

PLEASE **OBTAIN** INFORMATION FROM:

Mohammad B. Khan, MD
3195 S. Price Rd, Ste 150
Chandler, AZ 85248

Phone: 480-722-0239
Fax: 480-722-0240

PLEASE **SEND** INFORMATION TO:

_____
Office/Patient/Provider Name

_____
Street Address

_____
City, State, ZIP Code

_____ _____
Phone Number Fax Number

I Authorize the following information to be disclosed: (check all that apply)

____ Entire Records	____ MRI/MRA _____	____ Echo
____ Immunization Records	____ Psychiatric/Mental Health	____ Billing Records
____ Lab Report(s)	____ Alcohol/Substance Abuse	____ Other: _____
____ Carotid US	____ Sleep Testing	Date(s): _____

Reason for disclosure of information:

____ At my request ____ Continuing care _____ Insurance _____ Other: _____

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization at any time.
- I understand that once my health care information is disclosed as I have authorized, it could be redisclosed by the recipient and is no longer protected by Chandler Neurology & Sleep Disorders.
- I understand that signing this authorization does not cancel any rights I have under state or federal law.

Patient Signature: _____ Date: _____

Patient Legal Guardian: _____ Date: _____

CHANDLER NEUROLOGY & SLEEP DISORDERS
Medical Record Release

Name:_____ DOB:_____ Phone: _____

PLEASE **OBTAIN** INFORMATION FROM:

_____
Office/Patient/Provider Name

_____
Street Address

_____
City, State, ZIP Code

_____ _____
Phone Number Fax Number

PLEASE **SEND** INFORMATION TO:

Mohammad B. Khan, MD
3195 S. Price Rd, Ste 150
Chandler, AZ 85248

Phone: 480-722-0239
Fax: 480-722-0240

I Authorize the following information to be disclosed: (**check all that apply**)

____ Entire Records	____ MRI/MRA _____	____ Echo
____ Immunization Records	____ Psychiatric/Mental Health	____ Billing Records
____ Lab Report(s)	____ Alcohol/Substance Abuse	____ Other: _____
____ Carotid US	____ Sleep Testing	Date(s): _____

Reason for disclosure of information:

____ At my request ____ Continuing care _____ Insurance _____ Other: _____

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization at any time.
- I understand that once my health care information is disclosed as I have authorized, it could be redisclosed by the recipient and is no longer protected by Chandler Neurology & Sleep Disorders.
- I understand that signing this authorization does not cancel any rights I have under state or federal law.

Patient Signature: _____ Date: _____

Patient Legal Guardian: _____ Date: _____