SALMA MAZHAR M.D. P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize and request_____,
(Name, Address of facility)
and its authorized agents and employees to release the following information from the health records of:

_____ _____
Patient Name **Date of Birth**

_____
Social Security Number

The information is to be released to:

Salma Mazhar M.D. P.A
901 N. Galloway Ave, Ste. 107
Mesquite, TX 75149
Phone:(972) 216 – 5152 Fax: (972) 216-5154

This request and authorization applies to:

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

_____

☐ All healthcare information

☐ Other: _____

Reason for medical records request: _____
I understand that this authorization will automatically expire in six months from this date but may be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

I understand that my medical records may contain information that indicates that I have a communicable or venereal disease, which may include, but is not limited to, disease such as Hepatitis, Syphilis, Gonorrhea or the Human Immunodeficiency virus, also know as Acquired Immune Deficiency Syndrome (AIDS).

Information release may include alcohol and drug abuse records protected under the Code of Federal Regulations and psychiatric records, if any. Re-disclosure of this information by the recipient is prohibited without specific authorization. I waive all rights and privileges allowed by law relating to disclosure of confidential information relating to this authorization and release the facility, its agents and employees from legal responsibility arising from the release of this information.

_____ _____
Signature of Patient or person authorized to sign for patient **Date**

_____ _____
Witness Signature **Date**