AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's name: _____ Account # _____
Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

BIRJIS K. ALAM, M.D., P.A.
12781 Miramar Parkway, Suite 101
Miramar, FL 33027

3. The type and amount of information to be used or disclosed is as follows: (Include dates where appropriate).

Demographic information (such as name, address, telephone number, e-mail address, etc.)
Problem list
Medication list
List of allergies
Immunization record
Most recent history and physical
Most recent discharge summary
Laboratory results from (date)_____ to (date)_____
X-Ray and imaging reports from (date)_____ to (date)_____
Consultation reports from (doctor's names) _____
Entire record
Other_____
_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health Services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual
Names:_____
Organization:_____
Address:_____
_____
For the purpose of:_____
_____

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual/organization noted in #2 above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ . If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have question about disclosure of my health information, I can contact **Maxine** at (954) 437-2020.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, Relationship to Patient

_____

Signature of Witness