Khair Family Practice
AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION	**NAME:**_____ **DATE OF BIRTH:** _____ **Address:**_____ **Day Phone:** _____ **City:**_____ **State**_____ **Zip:** _____
Clinic/Hospital/Health Care Provider – (***Who*** has the information you want released?) **Please list the specific Hospital and/or clinic.**	**NAME:** _____ **Address:**_____ **Day Phone:** _____ **City:**_____ **State**_____ **Zip:** _____
Receiving Party (***Where*** do you want the information sent? ***Who*** may have the information?)	**NAME: Khair Family Practice Attention: Medical Records** **Address:125 Eagle Spring Dr, Stockbridge, GA 30281 Phone:770-213-3366 Fax:** 855- 516-2317 **Please send copies of files electronically or via CD.**
Information to be Released (***What*** do you want sent or released? Check the appropriate box.)	Routine Record Sets (indicate date(s) of service_____) D Clinic (office visit, lab, radiology, medicines, immunizations) D Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology) D Billing Records D Copies of Films/Images D Any and all records (includes ALL types of record listed below. If you want to include images and billing records, check those boxes.) Only records types checked below: D Discharge summary/note D Radiology reports D Emergency record(s) D Medication records D History & physical exam D Rehab records (PT/OT/ST) D Immunization/allergy record D Chemical dependency/ D Operative report D Laboratory reports D Pathology reports Substance abuse records D Consultations D Progress notes/clinic notes D Mental health records D Pathology slides/blocks D Other records specify record type(s) _____ OPTIONAL Limits - Disclose only records related to following: Date(s) of service/: Injury or illness:
Release Instructions (***How*** and ***When*** do you want the information?)	Date information is needed:_____ **Release Method / Format requested: (check one)** D ***Paper*** D ***CD/DVD*** D ***Fax*** **(patient care only)**
Purpose of Release (***Why*** is it needed?)	D **Continuing care** D **Transfer of care** D **Social security appeal** D **Insurance application *** D **Personal use or review *** D **Social security disability determination *** D **Insurance payment/claim** D **Litigation/legal *** D **Other*** _____ *** Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524**

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:_____
- Khair Family Practice will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Khair Family Practice records may include records that it received from other organizations. If these records have been used by Khair Family Practice and filed in the record Khair Family Practice maintains about you, these records may be released with your Khair Family Practice records.
- Khair Family Practice cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Khair Family Practice from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

_____ _____ _____

Patient/Legal Guardian Signature | Date | Authority to act on behalf of patient (attach document)