Khair Family Practice
125 Eagle Spring Drive
Stockbridge, Ga 30281
Phone: (770) 213-3366
Fax: (855) 516-2317

Authorization to Release and Disclose Patient Information

Name_____ Phone Number_____ Date of Birth_____
Address_____ State_____ Zip Code _____

I, _____ hereby authorize Khair Family Practice to release and/or disclose medical Information as listed below.

PLEASE CHOOSE ONE:

Please **REQUEST** Medical Records **FROM:** ◯

Name of Medical Office: _____
Address: _____
City, State, and Zip Code: _____
Phone Number: _____ Fax Number: _____

Please **SEND** Medical Records **TO:** ◯

Name of Medical Office: _____
Address: _____
City, State, and Zip Code: _____
Phone Number: _____Fax Number: _____

All Records: ◯

Specific Records: ◯ _____

***This authorization lasts for one year after the date you sign it, unless otherwise specified.**
***A photocopy/fax of this authorization will be treated as an original.**
***Your signature indicates that you have read and understand this form, and authorize release of your information.**
***Khair Family Practice cannot prevent re-disclosure of your information by the person or organization, who receives your records under this authorization. Also, 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 liability resulting from re-disclosure by the recipient.**

Signature: _____ Date: _____