Dr. Abdul Qadir, M.D.
Compassion-Health.com
1333 Howe Avenue, Suite 135
Sacramento, CA 95814
T: (916) 226 6876 T: (916) 333 1511

Authorization for Release of Protected Health Information

This form authorizes Dr. Abdul Qadir M.D. to release/obtain information as described below.

1. I hereby authorize

Sender/Institution:_____

Address:_____

City:_____State:_____Zip:_____

Phone #:_____Fax#:_____

2. Release to (check one):

☐ Patient or Authorized Representative

☐ *Dr. Abdul Qadir M.D.* 1333 Howe Ave. Suite 135 Sacramento, CA 95825

☐ Physician, receiving person, agency or institution:_____

Address:_____

City:_____State:_____Zip: _____

Phone #:_____Fax#:_____

3. Pertaining to the care of

Patient Name:_____Date of Birth: _____

Address:_____

City:_____State:_____Zip:_____

Also known as:_____Social Security #:_____

4. For the purpose of (check one): ☐ Continuing Care ☐ Insurance ☐ Legal ☐ Disability ☐ Patient Request ☐ Other (specify)_____

5. Description of Information

Disclosure is authorized for any and all information about medical history, mental and physical condition, including HIV infection, AIDS, or ARC, substance (drug or alcohol) use/abuse/treatment/testing and other personal information unless otherwise specified. If there is any part of the record you do not wish released, please indicate here:

6. Duration of Validity

This authorization is valid for 1 (one) year from the date of signing or until_____(date less than one year) unless revoked in writing by the undersigned prior to that date. The undersigned may revoke this by submitting a "Revocation of Authorization Form" to *Dr. Abdul Qadir M.D.* I understand that the revocation will not apply to any action taken in reliance on this authorization.

Dr. Abdul Qadir, M.D.
Compassion-Health.com
1333 Howe Avenue, Suite 135
Sacramento, CA 95814
T:(916) 226 6876 T:(916) 333 1511

7. Redisclosure

The information used and/or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy laws.

8. Understanding this Authorization

- This allows the release or obtaining of information that exits in the patient's medical record when the form is signed as well as information created after the form is signed until it expires.
- I understand my permission is voluntary and I/my child will receive treatment whether or not I sign this form.

9. Signature

By signing, I understand that I am authorizing *Dr. Abdul Qadir M.D.* to release/obtain information as described above.

_____

(Signature of Patient or Authorized Representative) (Date)

If signed by other than patient or parent of minor child, please print name and indicate relationship. Submit documents to show authority to request information on the patient.

Name:_____

Relationship to patient: ☐Parent ☐ Legal Guardian ☐Other:_____

_____

(Signature of Witness) (Date)