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AUTHORIZATION TO FURNISH MEDICAL REPORTS AND PROFESSIONAL INFORMATION

I hereby authorize Basheer Lotfi-Fard, MD or his designate to exchange with/obtain from:

	(name of person or organization)	
Information specified below re	garding the care of:	
эр		(name of patient)
		(alata of hinth)
		(date of birth)
☐ Attendance/Contact Records	☐ Assessment	☐ Medical Screenings/Evaulations
☐ Diagnosis	☐ Emergencies/Hospitalization	☐ Progress Notes
☐ Initial Evaluation	☐ HIV/AIDS infection	☐ Psychiatry Notes
☐ Treatment Summary	☐ Medication History/Lab Work	☐ Substance/Alcohol Abuse
☐ Other (specify):		
The above information is exch	anged to contribute to the patient's o	continuity of care.
authorization at any time by m I also understand that Dr. Lotfi benefits on my signing this aut	aking a written request to Dr. Lotfi-F -Fard may not condition treatment, p	payment, enrollment, or eligibility for elated to research and the purpose of
	(signature)	(relationship to patient)
		(date)
	(witness)	(date)

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