

Arshad Aqil MD PLLC

HIPAA - Patient Consent of Information (Revised 1/23/2026)

I, the patient, authorize Arshad Aqil MD PLLC and its staff to leave messages containing **Protected Health Information (PHI)** regarding scheduling, treatment, surgery, lab/radiology results, or other necessary information on an answering machine, voicemail, or with a specified individual. I understand that without this authorization, only minimal information (name, number) will be left. I may specify details and recipients below. I also consent to the mailing/faxing of requested results to my primary care physician or other involved providers.

To protect your privacy, HIPAA laws prevent us from sharing your medical records, billing details, or appointment information with anyone other than you, unless you give us written permission. If you would like to allow a spouse, family member, or friend to access your information - such as picking up documents, discussing care, or asking billing questions, please fill out below:

Name of Spouse, Family member, or Friend to Release PHI	Relationship	Phone number
1)		
2)		
3)		

Health Information to be disclosed upon the request of the person named above:

(CHECK EITHER “A” OR “B”)

A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, Mychart access, and billing, for all conditions)

OR

B. Disclose my health record, as above, **BUT DO NOT DISCLOSE THE FOLLOWING:**
(check as appropriate):

- Mental health records
- Communicable diseases (including HIV and AIDS)
- Alcohol/drug abuse treatment
- Other (please specify): _____

Authorization for Consent of Information and Acknowledgement for Privacy Practice

HIPAA – Notice of Privacy Practice Acknowledgement:

Please “check” if you would like a copy of Arshad Aqil MD PLLC Privacy Practice.

Patient's Name (PRINT): _____ Date of Birth: _____

Patient's Signature: _____ Date: _____