Comprehensive ID Care, PA

☐ **Shahbaz Ahmad, MD**
Internal Medicine & Infectious Diseases

☐ **Reni Johnson, RNP-C**

Consent / Authorization for Release of Information

Patient's Name: _____

Date of Birth: _____ Phone Number: _____

Covering the period of treatment from: _____ To: _____

1. I hereby authorize: (Where are you requesting records from?)

Facility or Provider Name:_____

Phone: _____Fax: _____

2. Information is to be released to: Above checked physician/ RNP-C @ 425 Old Newman Rd. Suite 402 Frisco, TX 75034 Phone: (972) 499-5551 Fax: (972) 499-9150

3. Information to be released

- ☐ All Medical Records
- ☐ Physician's orders
- ☐ Progress Note
- ☐ History & Physical
- ☐ Imaging Reports
- ☐ Lab Reports
- ☐ Pathology Reports
- ☐ Operative Reports
- ☐ Medication Records
- ☐ EKG
- ☐ Cardiology Reports
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Other _____

4. Purpose of Disclosure:

- ☐ Continuing Care
- ☐ Personal Use
- ☐ Billing/Claims
- ☐ Insurance
- ☐ School
- ☐ Employment
- ☐ Legal Purposes
- ☐ Disability Reasons
- ☐ Other _____

I acknowledge and agree that the term Medical Records Information may include: notes by the provider and other personnel, results, reports, correspondence, x-rays, as well as claims, billing, and payment information. I understand that this may include information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and / or psychiatric / psychological conditions unless specifically excluded.

By signing below, I am providing written consent for above provider and their bussiness to obtain copies of my medical records. so agree that photocopied signatures are valid for obtaining medical records.

Signature of Patient: _____ **Date:** _____