AUSTIN FAMILY PSYCHIATRY

Dr. Afshan Khan, M.D.

Phone: 512 902 6920
Office Address: 4407 Bee Cave Road, Building 5, Suite 512, Austin, TX, 78746

Authorization to Disclose Protected Health Information

Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

I authorize Austin Family Psychiatry and Afshan Khan M.D. to release medical records for

_____ DOB _____ / _____ / _____. My relationship to the
(Patient Name)

patient is: _____. My phone number and address are _____.
(Self, Parent, Guardian) *(Phone)*

_____.
(Street) *(City, State)* *(Zip Code)*

My email address is _____.
(Email Address)

I grant Dr. Khan permission to **request/release** information **to/from** the following:

_____ _____
(Name of person/entity with whom information will be shared) *(Phone Number)*

_____ _____
(Street Address) *(City, State)* *(Fax Number)*

and (if second person/entity is applicable)

_____ _____
(Name of person/entity with whom information will be shared) *(Phone Number)*

_____ _____
(Street Address) *(City, State)* *(Fax Number)*

Please release the following records:

___ Entire Medical Records

OR solely:

___ School Reports
___ Lab Results
___ Psychological Testing Results
___ Progress and Intake Notes
___ Hospital Treatment Records
___ Other: _____

_____ _____
Signature Date
(Parent or Guardian Signature if under 18)

Please note that our fax number is 512-287-5547 for medical records