

KHALID B. KHAN, M.D.

Family and Immediate Healthcare · 13425 Inglewood Ave, Hawthorne, CA 90250
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AUTHORIZATION FOR RELEASE OR DISCLOSURE OF MEDICAL INFORMATION

HIPAA Compliant

I, _____ (name of person signing authorization), DOB _____, authorize:

Name of Facility to Release From: _____

to release health information to:

Recipient: Khalid B. Khan, M.D. · 13425 Inglewood Ave, Hawthorne, CA 90250 · Fax: (310) 679-4236

Type of Records: Medical

Information to be Released (check all that apply):

- General Medical Information
- All Medical Records
- History and Physical Exam / Progress Notes
- Consultation Evaluations
- Radiology / Diagnostic Images and Reports
- Other: _____

The time period for the information selected above shall be from **Start Date:** _____ to **End Date:** _____.

Purpose of this release

This release is being made at the request of the patient for the purpose of review and evaluation.

Notice

Physicians, hospitals, and health plans are required by law to keep your information confidential.

My Rights

I understand this authorization is voluntary, and I may revoke this authorization at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received. I am entitled to receive a copy of this authorization.

Expiration of Authorization

Unless otherwise revoked, this Authorization expires _____. If no date is indicated, this authorization will expire **12 months** after the date of signing. A copy of this authorization is valid as the original.

Signature of Patient

Date