Yasmin B. Khan, M.D.
1080 W. Campbell Road, Suite 200
Richardson, TX 75080
Ph: 972-498-4510, Fax: 972-498-4511

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize:
Yasmin B. Khan, M.D.
1080 W. Campbell Rd. #200
Richardson, TX 75080

To release my records to:
____
____
____
PH _______________ FX ________________

I hereby authorize:
____
____
____
PH________________ FX___________

To release my records to:
Yasmin B. Khan, M.D.
1080 W. Campbell Rd #200
Richardson TX 75080
PH (972) 498-4510 FX (972) 498-4511

The following information from the medical record of:

Patient Name: _____________________________ Date of Birth: ______________
Date of Treatment: _________________________ SS#: _____________________

Information to be released:

- ☐ Consultation Reports
- ☐ Discharge Summary
- ☐ EKG/ECHO
- ☐ Laboratory Reports
- ☐ History & Physical
- ☐ Immunization Record
- ☐ Itemized Bill
- ☐ Progress Notes
- ☐ OP Report
- ☐ Pathology Report
- ☐ PT Records
- ☐ Psych Records
- ☐ X-ray Report/Films
- ☐ ER Records
- ☐ Other (specify): ____

The information above is to be released for the following purposes:

- ☐ Treatment/Consultation
- ☐ Patient Request
- ☐ Billing or Claims
- ☐ Attorney
- ☐ Social Security
- ☐ Other (Specify): __________________________________

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing records contains information in reference to drug and/or alcohol abuse. Psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.
Check one: ☐ **Yes** ☐ **No** _________________ **Initials**

I understand that if my medical or billing records contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.
Check one: ☐ **Yes** ☐ **No** _________________ **Initials**

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at the above address. This authorization will automatically expire 180 days from the date of my signature or unless revoked prior to that time or unless otherwise specified as follows: ____________________________

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will not longer be protected by the Health Information Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative

I understand that Yasmin B. Khan, M.D. may not condition my treatment whether I sign this authorization form. I authorize Yasmin B. Khan, M.D. to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for record copies.

____ ___________________________________
Signature of Patient or Legal Representative **Date**

Authority to sign if not Patient (documentation of authority required) ___________________________
Identity of Requestor verified via:
☐ Photo ID ☐ Matching Signature **Verified by:** __________________ Initials