Medical Records Release

Please complete the following information:

Patient Name: ______________________________DOB:______________________

Address: ____

Phone: ________________________SSN: _________________________________

I authorize my previous Dr. ___________________________Ph#:__________________

City: ______________________________Fax#:____________________

to disclose/release the following information*

(check all applicable):

- ☐ All records
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Pharmacy/prescription records
- ☐ Other ____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

Please send the records to:

Centennial Primary Care
Nuzhat Ahmed, M.D.
5520 Independence Pkwy #201
Frisco, Texas 75035
214-383-0001 Fax: 214-383-0068

The information may be used/disclosed for each of the following purposes:

- ☐ At my request (only the patient can check this box)
- ☐ For my health care
- ☐ For payment/insurance
- ☐ For employment purposes
- ☐ Other:

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

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Signature of patient or personal representative

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Liaison