

Mind & Peace Connection Center

Asim Rana MD PC

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Exton, PA 19341-2652

Phone 484-879-6173 Fax 484-879-6176

Authorization to disclose or obtain confidential client information

I hereby authorize ASIM RANA MD P.C. to disclose / obtain protected medical information as described below from the records of:

Patient's Last Name: _____ First: _____ M. Initial: _____

Address: _____

Date of birth: _____ Telephone Number: _____

To be disclosed to / obtain from: Name: _____

(Person / organization disclosure is being made to / obtained from)

Address: _____ Telephone # _____

Fax #: _____

Reason for Disclosure / Obtaining Information: _____ **Coordination of care** _____

I understand that:

- This authorization may be revoked at any time by writing, except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization revoking it will only prevent further disclosure.
- Information (except drug and alcohol information) disclosure pursuant to this authorization may be subject to re-disclosure by the individual / organization identified
- ASIM K RANA MD P.C. and its designee are hereby released from any legal responsibility or liability for disclosure of the specified information.
- The Authorization may include Mental Health, Drug & Alcohol Abuse and or HIV related information.

The information to be disclosed:

*****Check in box next to information you wish to have disclosed.

Financial Information	<input type="checkbox"/>	Medication Information	<input type="checkbox"/>
Medical Diagnosis/treatment	<input type="checkbox"/>	Mental Health Diagnosis	<input type="checkbox"/>
Laboratory Record	<input type="checkbox"/>	Progress Notes/Treatment Plans	<input type="checkbox"/>
Psychiatric Evaluation	<input type="checkbox"/>	Psychotherapy notes	<input type="checkbox"/>

(Two years from today.)

Authorization: Start Date _____ End Date _____

Signature of Client / Personal Representative: _____ Date _____

Guardian Signature _____ Date _____

Signature of Witness _____ Date _____