Midwest Medical Group

(P) (F)

I, ____________________ hereby authorize ____________________________

(Patient name) (Organization) ☆Previous Doctor

to release copies of medical records and other records concerning my treatment, including, but not limited to information concerning drug abuse or related conditions, alcoholism, psychological and psychiatric conditions, and including the release of information containing HIV testing, AIDS diagnosis, AIDS related conditions or sexual preference, or permit review of the same.

DATE OF BIRTH: ________________

( ) History and Physical

( ) Test results

( ) Office Notes

( ) Consultations

( ) Complete Medical Chart

( ) Other ______________________________

The above information is to be released to:

Name: Dr. Rashid Khan

Address: 8250 Winton Rd. Ste 200

City, State, Zip: Cincinnati, OH 45231

Phone #: 513-931-9600

Fax #: 513-931-1898

I understand that authorizing the disclosure of the health and information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be pretected by the law. I understand this authorization may be revoked at any time except to the extent actions have been taken prior to revocation. Thyis consent will expire in 60 days after the date below.

I acknowledge that I have read and fully understand this authorization applies to me.

Date: _______________ Signature: ____________________