IODHM
Bridge to quality care

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please list your Primary care doctor and/or other physicians

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my health care provider Syed Hussain M.D. to use or disclose my health information during the term of this Authorization to and from the recipient(s) that I have identified below.

Patient Name: _____ DOB: _____
Previous Name: _____ Last 4 digits of SSN: _____

1. Primary Care Doctor or Specialist:

Name: _____ Phone: _____ Fax: _____
Location: _____

2. Primary Care Doctor or Specialist:

Name: _____ Phone: _____ Fax: _____
Location: _____

This request and authorization apply to: Please check all that apply
___ All Healthcare information
___ ONLY Labs
___ Other: _____

Patient Signature: _____ Date: _____