



MD Health
CLINIC

Dr. Nimra Rana

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Authorization for Disclosure of Health Information

I hereby authorize _____

To release medical information from the records of:

Patient Name: _____ DOB: _____

Address: _____

DATES of Treatment Requested: _____

Information to be disclosed (check all applicable Items to be released):

☐ Discharge summary ☐ ER Records ☐ Progress Notes ☐ Treatment plans
☐ Discharge Instructions ☐ X ray reports ☐ Medication records ☐ Commitment papers
☐ History & Physical ☐ Labs ☐ Doctors orders ☐ HIV testing
☐ Consultations ☐ EKG / ECG tests ☐ Nurse's notes ☐ Therapy Notes
☐ Operative report ☐ Other (Specify) : _____

PURPOSE OR NEED FOR THE DISCLOSURE IS:

---- Continued Medical care ☐ Insurance ☐ Legal ☐ Personal use ☐ Other : _____

The Information May be disclosed to

Nimra Rana, MD

651 Route 73 North Suite 307 Marlton, NJ 08053

PH : 856 275 6780 Fax : 856-797-1612

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, Acquired Immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and or Human Immunodeficiency virus (HIV).

Fees: I understand and agree that there may be costs associated with this request in compliance with state copying laws.

X _____ Date: _____

(Signature of Patient or Patient representative)

If signed by a personal representative, a description of the representative's authority to act is as follows:

☐ Parent ☐ Legal Guardian ☐ Health care Power of authority

☐ Administrator ☐ Executioner of Estate ☐ Next of Kin ☐ Beneficiary