MUHAMMAD MOIN UDDIN M.D. AND RAHIMA AFROZA M.D
3900 west 15th street suite 107
Plano,tx 75075
Phone: 972-964-7773 Fax: 972-867-3640

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Child first and last name: DOB:

I hereby authorize my child's medical release from:

Clinic name: phone number: fax number:

To be released to:

Health and healing pediatric clinic
Muhammad Moin Uddin M.D and Rahima Afroza M.D
3900 west 15th street suite 107
Plano,Tx 75075
Phone: 972-964-7773 Fax: 972-867-3640

Information to be disclosed:

__Medical history/examination
__Immunization records
__Laboratory Test Results
__Imaging reports
__Growth Charts
__Other (specify)

Purpose of disclosure:

__futher medical care
__change of physician

Signature:

Also I ___ DO or ___ DO NOT (check one and initial on __) consent to release of information relating to psychiatric or psychological testing or treatment,biofeedback training,alcohol and or drug abuse diagnosis/treatment, or HIV(AIDS) testing.

I, the parent/guardian, agree that a photocopy or facsimile(fax) of this authorization may be considered valid, this authorization shall be valid for 120 days from the date of signature, this authorization can be revoked at any time prior to the expiration date.

I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may not be protected. I hereby release and hold harmless Health and healing pediatric, from all liability and damages resulting from a lawful release of my protected health information.

Print your name: Signature: Date:

Relationship to patient (circle one): self mother father guardian