Cognitive Psychiatry, PA
Dr. Sadaf Javaid
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Authorization to Use/Disclose Health Care Information

I authorize Dr. Sadaf Javaid to do one of the following: (Circle one)

Release Records to: ***OR*** **Receive Records From:** ***OR*** **Release and receive records:**

Name: _____

Address: _____

City, State: _____

Phone: _____

Fax: _____

This request applies to the following protected health information:

___All Information
___Appointments only
___Medication only
___Office Notes
___Billing Reports
___Laboratory Reports
___Other—Please specify_____

During the following time period or dates: _____

I am requesting the release of this information for the following reason (*circle one*)

Transfer of care **Coordination of Care** **Other: _____**

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2 1987]

This authorization will remain in effect until patient revokes this authorization in writing by sending written notification to my office address. However, your revocation will not be effective to the extent I have taken action in reliance on this authorization or this authorization was obtained as a condition of insurance and the insurer has a legal right to consent a claim.

Name of Patient: _____DOB: _____

Name of Guardian (if applicable): _____

Relationship: _____

Signature: _____Date: _____