SIBTE A. KAZMI, M.D.
814 Toll House Avenue
Frederick, MD 21701
(301) 662-8310

AUTHORIZATION TO REALEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize (Facility/Program)_____to release healthcare information of the patient named above to:

Name: Sibte A. Kazmi LLC Fax : 855-834-7491

Address: 814 Toll House Avenue

City: Frederick State: MD Zip Code: 21701

1. This request and authorization applies to following dates of service:_____

2. Please release the ☐ **Entire Medical Record OR** the following information (Check all that apply):

☐	History and Physical	☐	Operative/Pathology Report
☐	Consultation Report	☐	Pathology Slides/Block
☐	X-ray/Imaging Report(s)	☐	Lab Report(s)
☐	X-rays/Imaging Film	☐	Emergency Room Record
☐	Mammography *(Original, not copy)**	☐	Discharge Summary
☐	Photo(s)	☐	Abstract or Summary
		☐	Other _____

Method of Release

☐ Paper
☐ Fax

Please complete each of the following statements. If not complete, the information will not be released.

I ☐do ☐do notwant HIV/AIDS information released under this authorization.
I ☐do ☐do notwant mental health information released under this authorization.
I ☐do ☐do notwant drug/alcohol abuse treatment information released under this authorization.
I ☐do ☐do notwant developmental disability treatment information released under this authorization.

The purpose for release of the above information: ☐ Continued Care ☐ Insurance ☐ Legal
☐ At my request *(Patient only)* ☐ Other:_____

This authorization will expire within 1 year unless otherwise indicated. I understand that authorization is voluntary and may be revoked at any time in writing except to the extent that action has already been taken in reliance to this authorization. Subsequent re-disclosure or recopying of this information is not authorized without specific consent of the patient or authorized representative as provided in the Annotated Code of the State of Maryland, Article 4-302 (d).

I understand that I do not have to sign this authorization to ensure that I receive medical care.

_____ _____
Signature of Patient/Patient Representative **Date**

If signed by other than patient, state relationship: ☐ Parent ☐ Guardian ☐ Legal Representative
☐ Other:_____

*** Photo ID is required at the time of release.**

SIBTE A. KAZMI, M.D.
814 TOLL HOUSE AVENUE
FREDERICK, MD 21701
(301) 662-8310 PHONE
(855) 834-7491 FAX

HIPPA PRIVACY AND RELEASE OF INFORMATION AUTHROIZATION

Date :_____

Patient Name : _____

Patient DOB : _____

I, _____ here by authorize Sibte A. Kazmi, MD LLC and his affiliates, its

Employees and agents, to use and disclose protected health information (E.G., information relating to the diagnosis, treatment, claims payments, and health care services provided or to be provided to me which identifies my name, address, social security number, member ID number for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state laws.

I understand that I have a right to revoke this authorization by providing written notice to Sibte A. Kazmi, MD. How ever, this authorization may NOT be revoked if its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverages of services.

I have been advised of this practice's Privacy Policies, Release of Billing Information, Assignment of Benefits Policy, and grant the practice Medication History Authorization.

By signing this form, I represent that I am the legal representative of the member identified above and will provide written proof that I am legally authorized to act on the members behalf with respect to this authorization form.

I authorize the below listed individuals to access to medical record and Protected Health Information (PHI)

Name _____Phone _____Relationship_____

SIBTE A. KAZMI, M.D.
814 Toll House Avenue
Frederick, MD 21701
(301) 662-8310

Practice Of
Internal Medicine
&
General Practice

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

I acknowledge I received a copy of Dr. Sibte Kazmi's Notice of Privacy Practices.

_____
Patient Name (Print)

_____
Patient Signature

Address Line: _____

City: _____

State: _____

Zip: _____

Email: _____

If completed by a patient's representative, please print and sign your name in the space below.

_____
Patient Name (Print)

_____
Patient Representative (Print)

_____
Patient Representative's Signature

Relationship:

_____ Parent or guardian of minor.
_____ Guardian of conservator of an incompetent patient.
_____ Beneficiary or representative of deceased patient.

FOR STAFF USE ONLY

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Dr. Sibte Kazmi' Notice of Privacy Practices but was unable to for the following reason:

☐ Patient refused to sign
☐ Patient unable to sign
☐ Other _____

_____
Employee Name (Print)

_____
Date

Sibte A. Kazmi
814 Tollhouse Ave
Frederick, Md 21701
301-662-8310 Phone

Authorization for Release of Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without patient consent. If you to have you medical or billing information released to family members you must sign this form. Signing this for will only give information to family members indicated below. I authorize Sibte A Kazmi to release my medical and /or billing information to the following individual (s):

Name	Phone	Relation to patient

Patient Information:

I _____ understand I have the right to revoke this authorization at any time and that I have the right to receive a copy of the protected heath information to be disclosed. At cost of preparation fee and per page fee regulated by the state of Maryland. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient. You have the right to revoke this consent in writing.

Patient Signature_____ Date_____