Mohammad Jamil, P.C.
8765 W. Kelton Ln., B1-110
Peoria, AZ 85382
Tel (623) 670-7772 Fax (623) 444-2361

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____
Date of Birth: _____ Phone Number:_____

I hereby authorize: Practice Name: _____
Address: _____
Phone: _____ Fax: _____

to disclose a copy of the following information to: Mohammad Jamil, P.C dba iCare Internal Medicine.

☐ By the following method: ☐ Paper ☐ Fax ☐ CD

Covering the period(s) of health care:

FROM (date): 04/01/2023 - Present

Information to be disclosed: ☐ Last 3 Office Notes ☐ Last 3 Lab Reports ☐ Colonoscopy ☐ Mammogram
☐ _____

☐ **full** access to my electronic medical record through PATIENT CARE INQUIRY (PCI)

If applicable, I also give permission for the following to be disclosed (**please initial**):
____ acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
____ behavioral health services/psychiatric care
____ treatment for alcohol and/or drug abuse

This information is to be disclosed for the purpose of: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Practice. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. **If I fail to specify an expiration date, event or condition, this authorization will expire in One Year from date signed.**

I understand that any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the Privacy Officer at (623) 670-7772.

The Practice, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I have requested a copy of this Release. ____ YES ____ NO

_____
Patient or Personal Representative's Signature Relationship to Patient Date

_____
Witness Relationship to Patient Date