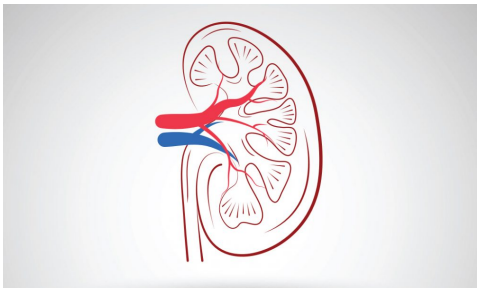

Mid-Florida Kidney and Hypertension Care, P.L.
P.O. Box 952951
Lake Mary, FL 32795
Phone: 407-265-2540 Fax: 407-265-9167

Authorization to Release or Obtain Healthcare Information from your Doctor

Patient's Name: _____ Date of Birth: ____/_____/_____

Social Security #_____-_____-_____ Phone: (_____)_____-_____

I request and authorize _____

To release my healthcare information to:

Fuad Afzal, MD and/or Sayed Husain, M.D.

Practice Name: Mid-Florida Kidney and Hypertension Care, P.L.

Phone: 407-265-2540 **Fax: 407-265-9167**

Address: 631 Palm Springs Dr. Ste#104 **City: Altamonte Springs** **State: FL** **Zip: 32701**

This request and authorization for medical records applies to:

- Labs, Recent office/Progress notes and Treatment
- Radiology, Test results, and Diagnosis
- Other: _____
- I DO NOT wish you to discuss my medical care with anyone other than those outlined in the privacy policy and myself.

Patient Signature: _____ Date Signed: _____/_____/_____

Witness Signature _____ Date Signed: _____/_____/_____

PLEASE READ IMPORTANT:

- **You have my permission to discuss my medical care with the following individuals:**
  (If No one put None or N/A)

_____ _____

_____ _____