AMINA JABEEN AHMED, M.D., P.A.
18400 Katy Freeway, Suite 440
Houston, TX 77094

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of confidential health information from the medical record of:

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Phone Number: _____

Information Released to:
Amina Jabeen Ahmed, M.D., P.A.
dba Premier Nephrology Consultants
P.O. Box 5525
Katy, TX 77491-5525

Please release the following:
__Problem List __Progress Notes __X-Ray Reports __Immunizations __History/Physical Exam __Lab Reports
__X-Ray Films __EKG Reports __Other Diagnostic Reports (specify) _____
__Other (specify) _____
Including Information (if applicable) pertaining to:
__Mental Health __Drug/Alcohol __HIV/AIDS* __Communicable Treatment
* I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agents of AIDS with the rest of my medical records. Initial _____ Date _____

Purpose or need of disclosure:
__Continued Patient Care __Attorney/legal __Personal Use __Disability Determination __Insurance Claim/application
__Other _____

I understand the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that the action has been taken in reliance on it. The consent will expire 90 days after the date of my signature unless otherwise specified.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set by the Texas State Board of Medical Examiners.