Comprehensive Care Medical Associates, P.C. 1205 Langhorne Newtown Rd., Ste. 309 Langhorne, PA 19047
Phone: 215-741-1963 / Fax: 215-741-1914

AUTHORIZATION FOR MEDICAL RECORD(S) REQUEST

Patient: _____ Date of Birth: _____

Address: _____

Home Number: _____ Cell Number: _____

This letter will authorize Dr Zafar Khan and his office to request a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information.

From the following office:

_____

_____

_____

_____

_____

At this time I am requesting the following:

_____Past 2 years

_____Complete record(s) or

_____Other: Specify: _____

To the following office:

Comprehensive Care Medical Associates, P.C.
1205 Langhorne Newtown Road Suite 309
Langhorne PA 19047

Reason for Requesting Records:

_____

I understand that I have the right to revoke this authorization and that I do not have to sign this authorization if I choose not to. I certify that the information is factual and accurate.

Signed: _____ Date: _____