**COMPREHENSIVE CARE MEDICAL ASSOCIATES,P.C.** 1205 Langhorne – Newtown Rd, Suite 309, Langhorne,PA. 19047;
Phone 215-741-1963 / fax 215-741-1914

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

**Patient** ______________________________ **Date of Birth** ______________

**Address** ______________________________ **Phone** ______________

**Phone** ______________ **email** ______________________________

This letter will authorized Dr Zafar Khan and his office to provide a copy, summary, or narrative of my Medical Records (as indicated by the check mark(s) below) or to otherwise confidential information. At this time I am requesting the following:

*PAYMENT DUE PRIOR TO RELEASE OF THE RECORDS: CHECK OR MONEY ORDER PAYABLE TO OUR COPY SERVICE:* ***ACCUDOCS***

_______ Past 2 years: Released to another Dr's office or Health Care facility for treatment- NO FEE

_______ Entire record (up to 94 pages) released to another doctor's office/health care facility - $49.50.
If records exceeds 94 pages, additional fees will apply.

_______Other: Specify: ______________________________
Price will depend on the amount records requested

**HIV/AIDS,** 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 agent of AIDS, with the rest of my medical records.
**INTIAL DATE**______________

**MENTAL HEALTH/ALCOHOL AND DRUG USE**. I consent to release of any positive or negative test result for mental health, or alcohol/substance abuse with the rest of my medical records **INTIAL DATE** ______________

**To the following person/office:**

Name ______________________________

Address ______________________________

Phone ______________________________ Fax ______________________________

Purpose of Disclosure: ☐ Medical Care Insurance ☐ Legal ☐ Transferring to New Provider Other (reason):

______________________________

I understand that Dr. Zafar Khan and his office will provide this information up to 30 business days from receipt of request, and service fee may be applied for preparing and furnishing this information;

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 ______________

Witness ______________________________ Date ______________