



M. A. Awan , M.D.
Abid Rasool, M.D.
Board Certified, Internal Medicine

Authorization to Release confidential Information

Date:-----

Patient Name:-----
Last First Middle

Date of Birth:----- Social Security Number:-----

I authorize Premcare Family center to Release / Obtain my medical information to / From,

(Name of Physician or Facility)

(Adress / City, State, Zip code)

(Phone Number)

(Fax Number)

for the purpose of review/examination and further authorize you to provide such copies thereof as may be requested. The foregoing is subjected to such limitation as indicated below:

----- Entire record ----- specific infomation i.e
-----psychiatric/Mental info ----- HIV ----- substance abuse

Date of authorization

Patient's signature

Patient's name

witness

Parent, Legal guardian or authorized Representative