TruCare Health Medical Corporation
Uzma Ahmed, M.D.

Authorization to release medical Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to release the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that I have the right to limit the type of information released from my medical records as in the case of HIV test results, mental health information, and alcohol and drug abuse information.

Name: _____D.O.B:_____
Address: _____
Phone # _____

Doctor to release medical records:

Name: _____Fax: _____ Phone: _____
Name: _____Fax: _____ Phone: _____
Name: _____Fax: _____ Phone: _____

Organization **receiving** the information:

Uzma Ahmed, M.D.
1234 W. Chapman Ave., Suite 101
Orange, CA 92868
Phone: (714) 532-6713 fax: (714) 532-1169

Specific description of the information to be disclosed:

_____

_____

The patient or the patient's representative must read and initial the following statements:

_____**initial**: I understand that I may receive a copy of this authorization. **This authorization is effective now and will remain in effect for six (6) months from the date signed.** I understand that the requestor may not further use or disclose the medical information unless another authorization is obtained from me, unless such use or disclosures is specifically required or permitted by law.

_____**initial**: I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any effect on any actions taken by the providing organization before they receive the revocation.

_____ _____
Patient Signature **Date**