Comprehensive Health Care PA

21922 Bellaire Blvd. Suite 600 Richmond TX 77407 - 905 Beville Rd. Suite B South Daytona FL 32119

Consent Of Use/Disclosure Of Health Information

I voluntarily consent to authorize my health care provider **RIAZ RAHMAN** to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient:

Purpose:

Information to be disclosed: I authorize the release of the following health information:
(check the applicable box below)

All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

Only the following records or types of health information:

Term: I understand that this Authorization will remain in effect:

- From the date of this Authorization until the date
- Until the Provider fulfills this request.
- Until the following event occurs

Disclosure: I understand that my health care provider cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Comprehensive HealthCare PA. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the USC Office of Compliance at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Signature		Date	

If Individual is unable to sign this Authorization, Guardian or Representative must fill the following information:

Name		Legal Relation		Date	