TAHIR
Surgical Clinic of Arizona

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT'S FULL NAME ______________________________

PATIENT'S DATE OF BIRTH ______________________________

PATIENT'S SOCIAL SECURITY NUMBER ______________________________

PATIENT'S ADDRESS ______________________________

____

RELEASE RECORDS ***TO*** **DR** TAHIR •

FROM: NAME: ______________________________

ADDRESS :______________________________

____

PHONE: ______________________________

FAX ______________________________

RELEASE RECORDS ***FROM*** **DR** TAHIR •

TO: NAME ______________________________

ADDRESS ______________________________

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PHONE ______________________________

FAX ______________________________

_______ **RELEASE ALL MEDICAL RECORDS OR**

_______**THE FOLLOWING DESCRIBED RECORDS**:

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For the purposes hereof, "medical records" shall include all confidential HIV & communicable disease related information (as defined in A.R.S.section 36-661), confidential alcohol or drug abuse related information (as defined in 42CFR Section 2.1 Et Seq.), and confidential mental health diagnoses/treatment information.
I may revoke this authorization at any time providing I notify the office of S. Zubair Tahir, MD in writing to that effect. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my right to confidentiality.

______________________________ ______________________________
SIGNATURE OF PATIENT **DATE SIGNED**

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PARENT/ LEGALLY AUTHORIZED REPRESENTATIVE and RELATIONSHIP TO PATIENT

______________________________ **EXPIRATION DATE**