M. N. Shamsi PC
1000 Germantown Pike
Unit H-4
Plymouth Meeting, PA 19462

Authorization to disclose or obtain confidential client information

I hereby authorize I MUHAMMAD NADEEM SHAMSI P.C : to disclose / obtain protected medical information as described below from the records of:

Patient's Last Name: ______________________ First: ______________________ M. Initial: _____

Address: ____

Date of Birth: ________________ Telephone Number: ______________________

To be disclosed to/obtain from: Name: ______________________________________
(Person/organization disclosure is being made to/obtained from)

Address: ______________________________________ Telephone#______________

Fax #:______________

Reason for Disclosure/Obtaining Information: _________***Coordination of care***______________

I understand that:

- This authorization may be revoked at any time by writing, except to the extent that information ha already been disclosed. If information has already been disclosed in reliance on this authorizatio revoking it will only prevent further disclosure.
- Information (except drug and alcohol information) disclosure pursuant to this authorization may b subject to re- disclosure by the individual /organization identified.
- MUHAMMAD NADEEM SHAMSI P.C and its designee are hereby released from any lega responsibility or liability for disclosure of the specified information.
- The Authorizations may include Mental Health, Drug & Alcohol Abuse and or HIV related information.

The information to be disclosed:

*****Check in box next to information you wish to have disclosed.

Financial information		Medication Information	
Medical Diagnosis/treatment		Mental Health Diagnosis	
Laboratory record		Progress Notes/Treatment Plans	
Psychiatric Evaluation		Psychotherapy notes	

Authorization: Start Date______________________ (Two years from today.) End Date______________________

Signature of Client/Personal Representative: ______________________ Date______________

Guardian Signature ______________________ Date ______________

Signature of Witness______________________ Date______________