

Crescent Primary Care Physicians
Rabia Family Medicine Ltd
Authorization to release Information

Patients Name _____
(Last) (First) (Middle Initial)

Address _____

Phone(____)_____ Date of birth _____ S.S# _____

I authorize (name of previous doctor) _____
(name)

(Phone) (Fax)

to release medical information from My/My childs medical records and send them to:

Name of new physician: ? Dr.Fowzia Ghouse
? Dr.Kaleem Khan/Rabia F M Ltd
? Dr.Aruna Galla

Address: 2132 Deep Water Lane
Naperville Il, 60564

Phone: (630)922-1400

Fax: (630)904-7378

- No Limitations
- Only information related to the following:
- Specific visits (Date(s): _____)
- Hiv/Aids
- Mental Health
- Substance abuse
- Tests/Xrays/Lab work(Date(s) _____)

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time to the extent that action has been taken in reliance thereon.

Signed _____ Date _____