Dr. Saqib Nakadar, D.O. Phone: (586) 983-4200 Fax: (586) 983-4226
37300 Dequindre Rd., Suite 104, Sterling Heights, MI 48310

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____
Previous Name: _____ Social Security Number: _____
I Request and Authorize _____ to release healthcare information of the patient named above to:

Name: Dr. Saqib Nakadar, D.O.
Address: 37300 Dequindre Rd., Suite 104
City, State, Zip: Sterling Heights, MI, 48310

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition or dates:

_____
_____

☐ All Healthcare Information

☐ Other: _____
_____
_____

☐ Yes ☐ No I authorize the release of my sexually transmitted disease* results, including HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that they may not further disclose these test results without first obtaining my specific written permission for such disclosure.

* Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papillomavirus, genital warts, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (human immunodeficiency virus), AIDS (acquired immunodeficiency syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____
Date Signed: _____