10007

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

SINAI PEDIATRIC ENDOCRINOLOGY
2411 W. Belvedere Avenue
Suite 205
Baltimore, MD 21215
PH: 410 601-8331 FAX: 410 601-8859

Patient's Name ____________________ Patient's Date of Birth ____________________

Patient's Street Address ____________________ Social Security Number ____________________

City, State, Zip Code ____________________ Phone Number ____________________

I, the undersigned, hereby authorize ____________________

☐ to **release** copies of medical records to: ☐ to **obtain** copies of medical records from:

☐ **Verbal** release only of medical information to:

Name of Person or Agency ____________________ Phone Number (   ) ____________________

Address ____________________ City, State, Zip Code ____________________ Fax Number (   ) ____________________

The purpose or need for such disclosure is ____________________

Dates of Service: ____________________

____________________ is authorized to release the following: (Please check information to be released) The medical records to be released may contain medical information pertaining to mental health services, drug and/or alcohol diagnosis and treatment, HIV / AIDS testing, HIV / AIDS results or HIV / AIDS information.

- ☐ Abstract (Summary, Op Report, Paths, Consults, H&P, lab work)
- ☐ Emergency Room Record
- ☐ Outpatient Surgery
- ☐ Discharge Summary
- ☐ Admission History and Physical
- ☐ Consultation Report
- ☐ HIV / AIDS Report
- ☐ Doctor's Office Notes
- ☐ Operative Report / Pathology Report
- ☐ Alcohol / Detox / Drug Abuse
- ☐ X-ray, EKG, EEG, Labs, Cardiopulmonary
- ☐ Physical Therapy / OT / Speech
- ☐ Nuclear Medicine
- ☐ Clinic
- ☐ Mental Health / Psychiatry
- ☐ Other ____________________

____

Signature ____________________ **Date** ________ **Time** ________ **Relationship to Patient** ____________________

Witness ____________________ **Date** ________ **Time** ________ **Clock #** ________

This authorization will expire within 1 year unless otherwise indicated. The consent to disclose information may be revoked by me at any time in writing except to the extent that action has been taken in reliance thereon, as set forth in the LifeBridge Health Notice of Privacy Practices. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. Subsequent re-disclosure or recopying of this information is not authorized without specific consent of the patient or authorized representative as provided in the Annotated Code of the State of Maryland, Article 4-302 (d) ***Photo Id may be requested at the time of release.**

MR# ________ Date Completed ________ Completed By ________ # pages ________