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

10007

✓ ______________________ 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 Sinai Pediatric Endocrine Associates

☐ 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 camp, school, MVA, FMLA

✓ ( ) ______________________ Phone Number

✓ ______________________ Address City, State, Zip Code

✓ ( ) ______________________ Fax Number

The purpose or need for such disclosure is ______________________

Dates of Service: ALL

______________________ 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 ______