LIFEBRIDGE HEALTH
CARE BRAVELY

10007

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete each section highlighted in yellow and fax or mail to:

Mail / Fax date BEFORE 06/30/2022:
Fax to 410-582-9436. Mail to 1405 Madison Park Drive, Ste 1 Glen Burnie, MD 21061

Mail / Fax date AFTER 06/30/2022-:
Fax to 410-469-5176. Mail to Lifebridge Health Medical Group, CPE Operations- 10 Crossroads Drive, Ste 208, Owings Mills, MD 21117

Patient's Name _____ Patient's Date of Birth _____

Patient's Street Address _____ Email _____

City, State, Zip Code _____ Phone Number _____

I, the undersigned, hereby authorize Lifebridge Suburban Physician Group II, LLC, dba Dr. Naomi Shaikh

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

Name of Person or Agency _____ ( ) Phone Number _____

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

The purpose or need for such disclosure is Transfer of care

Dates of Service: All 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 All records and notes

Print Name _____ **Date** _____ **Relationship to Patient** _____

Signature _____ **Date** _____

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 _____