School/Camp Year 20__ - 20__

LIFEBRIDGE HEALTH
CARE BRAVELY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO SCHOOL OR CAMP

All fields must be completed otherwise the release will not be accepted

Patient's Name

Patient's Date of Birth

Patient's Street Address

Email

City, State, Zip Code

Phone Number

By my signature below, I authorize Sinai Hospital of Baltimore, Inc., Pediatric Endocrine Division ("Sinai"), to release copies of medical records to:

Name of School or Camp

( ) Phone Number

Address

City, State, Zip Code

( ) Fax Number

The purpose for such disclosure is to facilitate the nurse at the school or camp to safely administer medication to the patient.

Sinai is authorized to release only those medical records of the patient as may be necessary, as determined by Sinai, for the nurse at the school or camp to safely administer medication to the patient, which may include office notes and medication orders.

Print Name

Relationship to Patient

Signature

Date

- ☐ Please send completed medicine form via patient portal, I confirm I have access
- ☐ I will come to the office to pick up completed medicine form, please call me
- ☐ I have provided a self-addressed envelope for completed medicine form, please mail

This authorization will remain valid for 1 year from the above date, unless I specify a shorter period.

This authorization to disclose information may be revoked by me at any time in writing as set forth in the LifeBridge Health Notice of Privacy Practices, a copy of which I have been provided. I understand authorizing the disclosure of the information identified above is voluntary and Sinai may not may not make treatment for the patient conditional on me signing this authorization. Subsequent re-disclosure or recopying of disclosed information is not authorized without specific consent of the patient or authorized representative as provided in Md. Health-Gen Code Section 4-302(d).

MR#

Date Completed

Completed By

pages