PATIENT RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ Date of Birth:_____

I, the Patient / Parent / or Authorized Representative request and give my permission to release my Medical Records. Unless otherwise revoked, this authorization will expire on the following date:_____.
If, I fail to specify an expiration date, this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary.

This information may be disclosed and used by the following individual:

Release To: Edward S. Orman, D.P.M., P.A.
5009 Honeygo Center Drive, Suite 213
Perry Hall, Maryland 21128
Phone: 410-529-4141

*Please Fax Records to: 410-529-0801

X_____ _____
Signature of Patient / Parent / Authorized Representative Today's Date

_____ _____
Printed Name of Authorized Representative Relationship

_____
Address and Telephone Number of Authorized Representative