AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient's Name ______________________________ Date of Birth ____/____/____

Patient's Contact Information: ______________________ Telephone No: ______________

I hereby authorize:

Jatinder S. Sekhon, M.D.
DR. SUSAN H. BARTON
10110 Molecular Drive, Suite 109, Rockville, MD 20850

Telephone no. 301-417-9528 Fax no.301-417-9558

□ Release To □ Obtain From

The above patient is requesting the following information be made available to or from:

____

Person/ Organization to receive information

Address:____

Fax: ____________________________ Phone no. __________________________

Information to be released:	***Purpose of Disclosure:***
□ All records	□ Change of Doctor
□ Office notes –Date ________________	□ Referral to specialist
□ Lab Reports – Date ________________	□ Disability Determination
□ Radiology reports – Date ________________	□ Insurance
□ Procedure Reports – Date ________________	□ Personal
□ Pathology Reports – Date ________________	□ Workers Comp
□ Others(specify) ________________	□ Other (specify) ________________

I understand that Maryland Law 4-304(3) allows us to charge a fee for duplication of medical records and any administrative charges. I understand that the medical records to be released may contain protected health information (PHI) related to hepattis, HIV status, AIDS, Sexually Transmitted Diseases,alcohol or drug use,or mental health services;and hereby authorize the release of this information.All information released will be handled confidentially.This authorization for disclosure is specific for this request only and is valid for one year from the date of this authorization release. ***I may withdraw this authorization at any time except to the extent that action has been taken in response theron.***

________________ ________________ ________________________ ________________

Signature of Patient Date Signature of Parent/Guardian Relationship