# AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient's Name _____
(please print)

I hereby authorize

**Sheo P. Sharma, M.D., P.A., F.A.C.O.G.**
**66 Painters Mill Road, Suite 106**
**Owings Mills, MD 21117**
**Phone: 443-394-0520**
**Fax: 443-394-0524**

( ) Release ( ) Obtain From

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

_____
Person/Organization to receive information

_____
Street Address

_____
City State Zip Code

_____ _____
Phone Number Fax Number

***Information to be released:***

( ) Complete Medical Record
( ) Laboratory Reports _____(dates)
( ) Procedure Reports _____(dates)
( ) Other _____
Please Specify

( ) Office Visit Notes _____(dates)
( ) Radiology Reports _____(dates)
( ) Consultation Reports _____(dates)

I understand that the medical records to be released may contain protected health information (PHI) related to Hepatitis, 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. ***I may withdraw this authorization at any time except to the extent that action has been taken in response thereon.***

_____ _____
Signature of Patient Date

_____ _____
Date of Birth Social Security Number

Name and Title of person releasing medical records: _____

Date Information was mailed/faxed: _____