

**MARYLAND URGENT CARE
9831 GREENBELT ROAD,
LANHAM, MARYLAND 20706
(301) 277-3555 Office
(301) 552-0098 Fax**

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____ Facility _____ to release the following information from the health records of _____ . Date of Birth: _____
Patient's Name

Address _____
Covering the period (s) of hospitalization from:
Date of Admission: _____
Date of Discharge: _____
Hospital Medical Record # _____
Outpatient Clinic Notes _____

Information to be released:

- a. Copy of (complete) health record(s)
- b. Discharge Summary
- c. History & Physical
- d. Operative Report
- e. Other

Information is to be released to Dr. Sherif Hassan, c/o Maryland Urgent Care.
Purpose of Disclosure: _____

I understand this consent can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

Specification of the date, event, or condition upon which this consent expires:

The facility, it's employees and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signature _____
Relationship to Patient _____
Date of Signature _____