## AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

1. **I AUTHORIZE**:

_________________________________________
Name of Receiving Person or Organization

_________________________________________
Street Address

_________________________________________
City, State, Zip Code

2. **TO RELEASE TO**:

Dr. Pavel Klein
6410 Rockledge Drive, #610
Bethesda, MD 20817
301-530-9744 (phone)
301-530-0046 (fax)

3. **INFORMATION TO BE RELEASED**: (Check all that apply)

_______Admission Notes
________Progress Notes
________Discharge Summary
________ Pathology Reports
_______Operative Reports
________Consultation Notes
_______ EEG's
________EKG's
_______Laboratory Reports
________Radiology Reports
_______**Entire Record**

4. **THE PURPOSE OF THIS DISCLOSURE IS**:

_____ Continued Medical Care _____ Personal _____Legal ______ Other

5. **By signing below, I understand and acknowledge the following**:

- That I may revoke this authorization at any time by presenting a written revocation to the Medical Director
- That information released pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations

_________________________________
Patient's Name (PRINT)

_________________________________
Patient's Social Security Number

_________________________________
Street Address

_________________________________
Patient's Date of Birth

_________________________________
City, State, Zip Code

_________________________________
Daytime Phone Number

_________________________________
Patient's or Representative's Signature

_________________________________
Date

_________________________________
Printed name of patient's representative

_________________________________
Basis of the representative's authority