## GAYLE S. SCHWARTZ, MD & ASSOCIATES

## PHYSICAL MEDICINE & REHABILITATION ELECTRODIAGNOSTIC TESTING

## Patient Authorization for Use/Disclosure of Health Care Information

Patient's name:			Date of Birth:
□ FOR OUR OFFICE TO	) SEND RECORI	<b>DS</b> :	
I request and authorize:	Gayle S. Schwartz, MD & Associates 1920 Greenspring Drive #125 Timonium, MD 21093		s
Name:		Name:	
Address:		Address:	
City, State & Zip:		City, State & Zip:	
T:	F:	T:	F;
I request and authorize:		Namo	
		_	F:
1,1	•	1,	r.
Signature of patient or patient's authorized representative			Date signed