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 RECORDS:**

I request and authorize: Gayle S. Schwartz, MD & Associates
1920 Greenspring Drive #125
Timonium, MD 21093

To send office notes and reports from my visits to the following physicians:

Name:_____ Name:_____

Address:_____ Address:_____

City, State & Zip:_____ City, State & Zip:_____

T: _____ F: _____ T: _____ F; _____

☐ **FOR OUR OFFICE TO RECEIVE RECORDS:**

I request and authorize:

Name:_____ Name:_____

Address:_____ Address:_____

City, State & Zip:_____ City, State & Zip:_____

T: _____ F: _____ T: _____ F: _____

To send all office notes and reports from my file to the following physician:

Gayle S. Schwartz, MD & Associates
1920 Greenspring Drive #125
Timonium, MD 21093

_____

Signature of patient or patient's authorized representative Date signed

If I request a copy of my office note and/or reports, I will be charged a fee per page and the cost of postage. Total amount is due, by cash or check, before sending of the requested records.