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

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: _____

_____

Signature of patient or patient's authorized representative Date signed