Optimal Health Physicians
15235 Shady Grove Road, Suite 102, Rockville, MD 20850
Phone: (301) 330-9430 Fax: (301) 330-6515 www.ohpmd.com

Authorization to Treat

Patient Name ____ Date of Birth____________________

I hereby authorize medical treatment by Norton L. Fishman, MD, FACP, CNS and members of the medical/clinical staff of Revitalize LLC / dba Optimal Health Physicians. I understand that the practitioners are not primary care providers.

I authorize the release of any necessary information including medical records to my insurance carrier and other entities in accordance with HIPAA regulations and the Optimal Health Physicians Statement of Patient Privacy. I permit a copy of this authorization to be used in place of the original.

I may revoke this authorization at any time in writing.

I certify that I represent only myself, or individual(s) for whom I am a guardian, and I am not here on behalf of a third party.

Signature ____ Date_______________

If signed by a person other than patient, state the relationship to patient:

☐ Parent ☐ Legal guardian ☐ Medical power of attorney

Date of Signature