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

Release of Information

Patient Name ____ Date of Birth______________________

Authorization

I authorize Optimal Health Physicians to:

☐ DISCUSS MY MEDICAL CARE with Permitted Individuals identified below.

☐ RELEASE MY MEDICAL RECORDS to Permitted Individuals identified below.

This authorization shall be effective for medical information generated:

☐ Up to and including the date of signature, or

☐ Until revoked by me or my legal representative.

I understand that I may revoke the preceding authorizations in writing by me or my legal representative at any time.

Permitted Individuals

I give permission for Optimal Health Physicians to Discuss or Send information (as described above) to the following individuals.

Full Name ____ Phone ______________________________

Full Address ____

Full Name ____ Phone ______________________________

Full Address ____

Signature

Signature ____ Date_______________

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

☐ Parent ☐ Legal guardian ☐ Medical power of attorney