AUTHORIZATION TO REQUEST OR RELEASE PROTECTED HEALTH INFORMATION

Patient Name_____ D.O.B. _____

Address _____ SS#:_____

_____ MR#_____

I hearby authorize **Mark Sklar, M.D. 3 Washington Circle, Suite 303; Washington, D.C. 20037 Phone: 202-887-4769; Fax: 202-223-2552 to request or release my medical records.**

TO/FROM: _____

_____

_____ The following:

( ) Inpatient care on _____

( ) Emergency care on_____

( ) Ambulatory/Outpatient Care on_____

( ) Complete Medical Record ( ) X-Rays/Imaging Studies ( ) Abstract

( ) Laboratory Reports_____ ( ) Discharge Summary ( ) Operative Report

( ) Pathology Report ( ) Other_____

I ( ) do ( ) do not wish to have information about HIV/AIDS released under this authorization.

I ( ) do ( ) do not wish to have mental health records released under this authorization.

I ( ) do ( ) do not wish to have information about drug/alcohol abuse treatment released under this authorization.

The purpose for release/ or request of the above information is indicated below:

( ) Continued Care ( ) Insurance ( ) Legal

( ) At my request (patient only) ( ) Other (specify)_____

Patient's name_____

Patient's Signature_____ Date:_____