Neurology Clinic of Maryland, Inc.
Dr. Sheetal Harish Wagle, MD
10770 Hickory Ridge Road, Columbia, MD 21044
Phone: 410 988 4013 Fax: 928 832 1095

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:____

Date of Birth:______________________________Social Security #_______________________

Patient Address:____

____

I request and authorize release healthcare information of the patient named above to:

Neurology Clinic of Maryland, Inc. ;
10770 Hickory Ridge Road
Columbia MD 21044

This request and authorization applies to:
Healthcare information relating to the following treatment, condition, or dates:

____

____

All healthcare information

Other:____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

I authorize the release of my STD results, HIV/AIDS testing, whether negative or Positive to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. **Yes**___ **No**___

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. **Yes**___ **No**___

Patient Signature:
Date Signed:

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.