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(301) 662-8477 FAX (301) 662-4293

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Physicians Name: _____

Address _____

Phone Number _____ Fax Number: _____

Patient Name: _____ DOB: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

I authorize you to release copies of my medical records to :

Oncology Care Consultants
Elhamy D. Eskander, M.D., F.A.C.P.
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Brian M. O'Connor, M.D.
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As required by Maryland law, I give special permission to release any information regarding the following conditions which may or may not be present: **(Please initial on line(s) below to indicate that you grant special permission to release this information to the party above)**

_____ Substance Abuse _____ HIV Information _____ Mental Health

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance thereon, and that there may be a charge for this information.

Reason for request: _____

Signed: _____ Date: _____

Relationship to Patient: _____

Witness: _____