AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
MEDICAL INFORMATION RELEASE

The undersigned hereby authorizes and requests:

Drs Shanahan and Ferguson PC

of this address:

120 Speer Road, Bldg. B
Chestertown, Maryland 21620

To provide:

____

of this address:

____

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with a copy of the medical records of the below referenced patient. This authorization is valid for:

__ Any and all information related to past and present medical histories, diagnoses and treatments.

__ The medical records concerning the period from _____________ to ____________

Patient's Name: _________________________ Date of Birth: ________________

Patient's Address: ____

Social Security (last 4 digits): _______________

Signature: ____ Date: _________________