Drs. Shanahan and Ferguson PC
120 Speer Road, Bldg B
Chestertown, Maryland 21620
410-778-9300 (Fax) 844-899-3778

Authorization Form for Use and Disclosure Of Protected Health Information

Patient Name: _____

Persons or group of persons authorized to receive my medical information (please list names of persons or company:

I understand that I may revoke this authorization in writing at any time except to the extent that action on this authorization has not already occurred.

This authorization becomes effective on this date: _____

_____ _____

Patient or Representative Signature Date

_____ _____

Name of Personal Representative Relationship to Patient