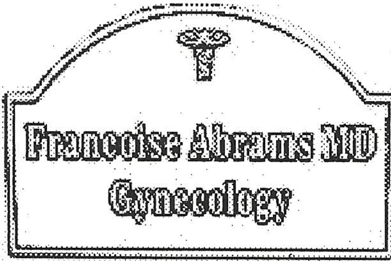

Francoise Abrams, M.D., FACOG
5073 Ten Oaks Rd.
Clarksville, MD 21029
Howard County

W - 410-531-2245
F - 410-531-2246

Authorization to Release Information

Patient Name: ______________________________

Address: ______________________________

____

Phone #: ____________ **Date of Birth:** ____________ **Medical Record #:** ____________

I hereby authorize **Francoise Abrams M.D.** to release medical information from my medical record to:

Name of Doctor, Hospital, etc.: ______________________________

Address: ______________________________

City: ____________ State: ____________ Zip Code: ____________

For the purpose of review/examination and further authorize you to provide such copies thereof as may be requested. The foregoing is subject to such limitation as indicated below:

☐ Up to two years past medical history and a third year health assessment (if available).

☐ Specific information: ______________________________

☐ I give special permission to release information regarding HIV data to the Doctor indicated above – **Initials:** ______

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Reason for Request: ______________________________

Signed: ______________________________ **Date:** ____________
(If not patient, state relationship)

Witness: ______________________________

FOR OFFICE USE ONLY

Received: ____________ Completed: ____________

Notes: ______________________________

____

____

____

Signed: ______________________________