## Saluja Medical Associates Authorization to Release Information

	(Name of Patient)	
(Date of Birth)	(Social Security #) hereby authorize	<b>)</b>
	(Medical Facility and Address)	

Its director or designee or Medical Records Department to release information contained in any medical record, including information about Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), including substance abuse treatment records protected under the regulations in code 42 of Federal Regulations, Part 2, if any; psychological and social service records, including communications may by me to social worker or psychologist, if any; to the individuals or organizations listed below under the conditions listed below.

- 1. Name of Organization: Saluja Medical Associates (Primary Care Physicians)
- 2. Office Locations:

Address	<b>6821 Reisterstown Rd</b> Suite 106, Baltimore, MD 21215	<b>821 North Eutaw St.</b> Suite 301, Baltimore, MD 21201	<b>702 W 40<sup>th</sup> Street,</b> Baltimore, MD 21211
Phone	410.358.6450	410.523.1404	410.235.8885
Fax	410.358.8511	410.523.1406	410.235.8954
Disclosed			

- 3. Specific type of information to be disclosed: All medical records including History and Physical, Progress notes, consultations, blood work, radiological testing, procedures/surgery and any hospital records.
- 4. The purpose and need for such disclosure: **CONTINUITY OF MEDICAL CARE**
- 5. This consent is subject to revocation at any time, except in those circumstances in which the Hospital has taken certain actions on the understanding that this consent will continue unrevoked until the purpose for which the consent was given shall have been accomplished. However, any consent given with the respect to substance abuse records shall have a duration of no longer than that reasonable necessary to achieve the purpose for which it is given.

Signature of Patient/Guardian	Signature of Witness	
DATE	DATE	