Hempel Sanderoff Wellness

9712 Belair Road, Suite 100; Nottingham, MD 21236

443-588-8984

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization will not expire except when revoked by the patient, legal guardian, power of attorney, or healthcare surrogate. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written request to the office staff. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected under federal privacy laws or regulations. A copy of this authorization may be utilized with the same effectiveness as an original. I am entitled to receive a copy of this authorization.

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Signature of patient/Guardian/Power of Attorney/Healthcare Surrogate Date

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Printed Name Relationship to patient (if applicable)