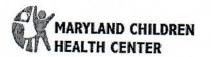


Mary A. Ogunsanya, MD, FAAP, Board Certified Infants, Children & Adolescents

12150 Annapolis Rd, Suite 208 Glenn Dale, MD 20769 Phone: 301-218-0398 Fax: 301-218-0040

6130 Oxon Hill Rd, Suite 202 Oxon Hill, MD 20745 Phone: 301-567 1767 Fax: 301-839-6128

Patient Medical Records Release Form		
Patient Name: Address:		D06:
Phone Number:		to
I hereby authorize:		ω
beneated finding up the desire invalidate and an experience to be a second of the control of the		_
To release copies of my medical record	s to: Maryland Children Hea	llth Center
	12150 Annapolis Rd, St	uite 208
	Glen Dale, MD 2076	9
	6130 Oxon Hill Rd, Sui	te 202
	Oxon Hill, MD 2074	5
I Authorize release	of information of the following po	rtion of my medical records:
Entire medical record		
Immunization Only		•
Labs & X-rays		ă.
Patient is here		
mai mis aumorization may be revoked a	at any time by giving an oral or writed alid authorization. I understand the	the date of signature. However, I understand litten notice to the medical office. A photocopy at once my medical records have been released, the released copies.
		y and all liability which may arise as a result of
Should my case require review by gove final determination, it is with my conserprofession for this review.	erning agency or another medical part that a copy of those records will	rofession actively involved in my care to make a be submitted to the agency or medical
Parent/Legal Guardian Signature:		Date
Relationship to the patient:		S. CANDELINA



18+ Patient Consent Authorization Form

	authorize Maryland Children Health Center to
disclose information regarding	
1. My entire chart	
2. Lab work results ONLY	
3. None of the above	
To:	Relationship:
	Date:/
Patient Signature (18 yrs or older)	
Cell Phone Number (or best # to reach me at) Please notify me first of any LAB RESULTS.	
Authorization for	or Parental PORTAL Access
I hereby give Maryland Children Health Center HEALTH INFORMATION on my PORTAL account	permission to give my parent access to my PROTECTED
Parent name gaining access:	
Davis a Gi	Date://
Patient Signature	
inese authorizations are val	id until otherwise rescinded by myself.
Preferred Contact Methods: (circle one for eac with your Carrier)	h method): Message and Data Rates may apply, check
Medical Issues: Cell Phone / Text to Cell / Emai	i de la companya de
Appointment Reminders: Cell Phone / Text to C	ell / Email
Recall Notices: Cell Phone / Text to Cell / Email	
Billing Statements: Mail Address / Text to Cell /	Email
General Practice Notices: Cell Phone / Text to C	ell / Email
Patient Portal Access: No/Yes If yes, use	
Email:	