LORRAINE OFORI-AWUAH, M.D., P.A.

I _____ hereby authorize the release of copies of my medical records to:

LORRAINE OFORI-AWUAH, M.D., P.A.
White Marsh Professional Center
5430 Campbell Blvd, Suite 214
White Marsh, MD 21236

Attn: Dr. Lorraine Ofori-Awuah
410 933-4970 (Phone)
410 933-4971 (Confidential Fax)

This authorizes Dr. Ofori-Awuah to release and/or obtain all pertinent information with regards to the diagnosis, treatment, and prognosis of conditions treated while under care. The medical records to be released may contain medical information pertaining to psychiatric, drug, and/or alcohol diagnosis/treatment. This also authorizes Dr. Ofori-Awuah to speak to the treating physicians about medical and work issues and the treatment plan. This authorization will expire in 90 days.

The medical records requested are for the following time frame:

_____

The purpose or need for such disclosure is for continuing evaluation and/or treatment at Dr. Ofori-Awuah's office. You are authorized to release the following medical reports:

- All medical reports, treatment notes and diagnostic studies
- Employees Health/Personal Records
- Other

Patient Signature: _____

Social Security #: _____

Date of Birth: _____