Tayo Oyegbile-Chidi, M.D., Ph.D.
8000 Westpark Drive, Suite 140, McLean, VA 22102
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Authorization to Release Protected Medical Information

Patient's Last Name:	First:		Date of Birth:
Street Address:			Home Phone:
City:	State:	Zip Code:	Cell Phone:

I hereby give Tayo Oyegbile-Chidi M.D., Ph.D. authorization to (specify):

☐ Discuss Information with*:

Company/Provider/Person Name:	
Address:	
Phone:	Fax:

Covering the period(s) of treatment from _____ to _____ / ☐ All

Information to be Discussed:

☐ Records – Date(s) specified above

☐ Lab Work – Date(s) specified above

☐ Other (specify) _____

For the purposes of:

☐ Coordination of care with another provider

☐ Moving/Transferring Care

☐ Insurance/Disability/Legal

* I understand that there may be a fee associated with this discussion. The fee (s) associated with this discussion authorization request will be the sole financial responsibility of the patient and/or their authorized representative.
I understand that this authorization will expire in **ONE YEAR** unless otherwise indicated here:

☐ Until records are obtained ☐ 6 months ☐ Never ☐ Other: _____. I understand I may revoke or edit this authorization at any time by providing written notification; however this will not affect actions taken prior to the receipt of my alteration. In the case of a minor, this authorization will expire once the patient turns 18 years of age.

_____

Printed name of Patient or Authorized Representative

*If you are not the Patient, indicate relationship to Patient: ☐ Parent or Legal Guardian ☐ Power of Attorney

_____ _____

Signature of Patient or Authorized Representative Date