Pandora
FAMILY MEDICINE

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Authorization for Release of Information

Patient Information:

Patient Name: _____

Date of Birth: _____

I, _____, hereby authorize Pandora Family Medicine, located at 6300 Baltimore Ave, University Park, MD 20782, to collect the following medical information as requested:

☐ **Medical Records:**

All medical records, including but not limited to:
Office visit notes, Laboratory and diagnostic test results, Radiology reports, Surgical reports
Immunization records, Medication history, Allergies and adverse reactions, Pathology reports
Progress notes, Consultation reports, Discharge summaries

☐ **Date range:** _____ **through** _____.

☐ **Office or Hospital:** _____

Address: _____
City: _____
State: _____
Zip Code: _____
Phone: _____
Fax or email:_____

I understand that this authorization is voluntary, and I have the right to revoke it at any time. The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

This authorization will remain in effect until revoked earlier in writing. I understand that I may revoke this authorization by submitting a written request to Pandora Family Medicine.

I acknowledge that Pandora Family Medicine cannot guarantee the confidentiality of any information disclosed pursuant to this authorization once it has been released.
I understand that I have the right to receive a copy of this authorization after I have signed it.

Patient Signature: _____

Date: _____

Revised and Finalized on August 26th, 2025.