Dr. Sharon Silverman, MD
10910 Little Patuxent Parkway
Suite 105R
Columbia, MD 21044
P: (410)964-5311
F: (410)964-8578

RE: ________________________________

DOB: ____/____/____

Attention: ___________________________

FAX: ________________________________

I am sending this request to you for all medical records on the above noted patient in regard to his/her last 5 years of care/treatment. We are requesting, labs, clinical notes, radiology, surgical care follow up information, and any other relevant studies.

Below is a written signature from the patient requesting this release be authorized and that medical information be forwarded to the above office.

Patient Signature: ________________________________ Date: ______________

Faxed Date: ____/____/____ Confirmed Date: ____/____/____