



Consent To Release Medical Records

I hereby grant permission for my medical records as checked below to be released

from: _____

to: Heike B. Bailin, MD
shapevolution™, LLC
5454 Wisconsin Avenue
Suite 1435
Chevy Chase, MD 20815

Name of Physician, Clinic, Institution

Phone 202.387.8814
Fax 202.467.9589

Mailing Address

e-mail DrBailin@ownyourshape.com

Phone Number

Fax Number

for the purpose of (please check all that may apply):

- Continuity of my medical care
- Coordination of my medical care by different providers
- Insurance purposes
- Legal purposes

Please release all checked items:

- Results of Laboratory testing (serology, urine analysis, etc.)
- Cardiac testing (ECG, reports of echocardiograms, stress tests, etc.)
- Radiology reports (X-rays, CT scans, MRI, DEXA, etc.)
- Discharge summary from _____
- Progress Note(s) from _____
- Consult Note(s) _____ from _____
(Specialty)
- Complete medical record from _____ to _____

with the exception of _____.
(Indicate tests you do not wish to be released)

This authorization expires on _____.

Patient Name – please print

Date of Birth

Current Patient Address and Phone Number

Patient Signature

Date and Time