

JOAN SMITH, D.O.; P.A.



Family Practice
31664 Old Ocean City Road
Salisbury, MD 21804-1800

PATIENT NAME: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

I AUTHORIZE _____ TO RELEASE ANY AND ALL

MEDICAL RECORDS TO: Joan Smith DO; PA
 31664 OLD OCEAN CITY ROAD
 SALISBURY, MARYLAND 21804-1800

PATIENT SIGNATURE: _____

WITNESS: _____

DATE: _____

- MAILED AT PATIENT REQUEST TO THE ABOVE DOCTOR'S OFFICE
- PICKED UP BY PATIENT

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Fax: (410) 860-5191
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