Whitford Family Medicine – 102 Schubert Drive – Downingtown, PA 19335
Phone: 610-873-2155 – Fax: 610-873-8494

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: _____D.O.B. _____

I, _____, HEREBY AUTHORIZE _____

TO OBTAIN ( ), RELEASE ( ) THE FOLLOWING SPECIFIC INFORMATION REGARDING THE FOLLOWING TREATMENT DATES: _____.

CHECK INFORMATION TO BE RELEASED: __ All Records ___ HIV related inf.* __ Discharge summary __ Consultations __ Drug and Alcohol Related Information * __ Radiology Reports __ History and Physical __ Mental Health Information * __ Laboratory Reports __ Other _____

INFORMATION TO BE RELEASED TO:

Individual or organization_____

Address: _____

_____

_____

I understand that this information is being requested for the specific purpose of:

_____

I have been informed that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) Written or oral communication to the medical record custodian of these physician(s) medical practice. Under Pennsylvania Law (Act 148). If psychological reports are to be sent, I have been informed of my right, subject to Section 5100-34 of the Mental Health Procedures Act 1984, to inspect the information to be released.

THIS CONSENT SHALL BE IN EFFECT FOR 180 DAYS FROM THE DATE SIGNED UNLESS SPECIFIED OTHERWISE BY THE PATIENT TO EXPIRE ON:_____(NOT TO EXCEED 180 DAYS).

_____ _____

Signature of Patient/Legal Guardian Date

_____ _____ _____

Witness Relationship/Title Date

INSTRUCTIONS:

1. Complete all blanks.
2. Return form with original signature(s).
3. Return for "attention medical records".

*** CHECKING THESE BLANKS WILL ALLOW RELEASE OF SPECIFIC INFORMATION TO THE ABOVE NAMED INDIVIDUAL/ORGANIZATION**