AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: ___________________________________ Date of Birth: _________________________________

Home Phone Number: _____________________________ Mobile Phone: _________________________________

Address: ____

Release Records **to** practice(s):

____

Release Records **from** practice(s):

____

Information and Dates to be Released:

____

____

These Records are Needed: ____ For Personal Use ____ For Continuation of Care

I understand that: My medical record may contain information of a sensitive or extremely private nature, including, but not limited to, a history of substance abuse, psychiatric or psychological disorders, abnormal test results, various prescriptions, results of HIV testing, history of sexually transmitted diseases, history of diseases transmitted by intravenous drug use or other high risk behavior, hospitalizations, surgeries, and any other medical or psychological disorder for which I may have been treated.

a) This authorization may be revoked/ modified at any time by writing to Doylestown Health Primary Care except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.
b) The hospital will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.
c) Information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by federal privacy regulations.
d) I understand that I cannot be compelled to authorize release of any of my medical records.

_____ This authorization expires on _____________(*Date*) _____ This authorization has no expiration date

____ _______________
Patient Signature Date

If person signing is someone other than the patient:

____ _______________
Signature Date

____
Print Name

____
Relationship to patient **and** authority to sign (e.g., legal guardian, Power of Attorney)