Doylestown Health
Physicians

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)