Wrightstown Family Medicine, P.C.

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AUTHORIZATION TO RELEASE MEDICAL RECORDS:

PATIENT INFORMATION:

Name (Print)	DOB	SSN
_____	_____	_____

INFORMATION TO BE RELEASED FROM:

Name of Facility or Provider	Phone Number	Fax Number
_____	_____	_____

INFORMATION TO BE SENT TO:

Name of Facility or Provider	Phone Number	Fax Number
Wrightstown Family Medicine	215-598-1200	**215-598-3912**

****ANYTHING OVER 20 PAGES, PLEASE MAIL TO THE ADDRESS BELOW****

INFORMATION TO BE RELEASED: (check one)

_____ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
_____ All medical records
_____ Specific Information (Please specify):

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial)

____ Drug/Alcohol abuse/treatment and diagnosis
____ HIV/AIDS diagnosis/treatment/testing
____ Sexually transmitted disease
____ Mental illness or psychiatric diagnosis/treatment

Signature: _____ Date: _____
(Patient, Guardian*, or Authorized Representative*)