

Wrightstown Family Medicine, P.C.

Paul M. Caracappa, D.O.
Ashley Von Dohlen, P.A.
Rebecca Martens, P.A.

****PLEASE MAIL TO OFFICE IF RECORDS ARE OVER 20 PAGES! IF 20 PAGES OR LESS PLEASE FAX****

**PLEASE DO NOT SEND RECORDS ON A DISC!
AUTHORIZATION TO RELEASE MEDICAL RECORDS:**

PATIENT INFORMATION:

Name (Print) _____ DOB _____

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 _____ 215-598-1201

****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 _____ Sexually transmitted disease
_____ HIV/AIDS diagnosis/treatment/testing _____ Mental illness or psychiatric diagnosis/treatment

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