Doylestown Health
Physicians

Doylestown Health Primary Care Spruce Street
300 Spruce Street
Doylestown, PA 18901
Phone: (215) 230-7800 Fax: (215) 2307993

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____

Date of Birth: _____ Telephone: _____ _____ _____

Social Security # _____ _____ _____

Address: _____

Release Records to/from: _____

_____

Information and Dates to be Released: _____

_____

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

I understand that:

a) 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.
b) 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.
c) The hospital will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.
d) Information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by federal privacy regulations.
e) 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)

Photo ID Type and Number: _____
Associate's Signature: _____ Date _____