

MEDICAL RECORDS RELEASE FORM

I hereby authorize: _____

to release the following information from the health record(s) of:

Patient Name: _____

Address: _____

Date of Birth: _____

- ____ Any and all general information regarding my condition and treatment
- ____ Mental health, psychiatric and/or psychotherapy treatment records
- ____ Drug and/or alcohol treatment records
- ____ Confidential HIV-related information

The information is to be released to:

Doylestown Family Medicine, P.C
Elliot H. Schnur, M.D.
300 Spruce Street
Doylestown, PA 18901
T: (215) 230-7800 F: (215) 230-7993

Patient or Guardian Signature Date

Witness Signature Date