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.
201 Farm Lane
Doylestown, PA 18901
T: (215) 230-7800 F: (215) 230-7993

_____ _____
Patient or Guardian Signature Date

_____ _____
Witness Signature Date