Chalfont Family Practice
65 E. Butler Avenue, Suite 201
New Britain, PA 18901
(215) 822-3113

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Patient Name: ____

Date of Birth: ______ / ______ / ___________ Social Security #: ________ - ________ - ___________

I, _______________________________________, understand that my medical record contains confidential medical information. If I have discussed certain sensitive information with my Provider, my medical record information includes alleged or actual drug/substance abuse; testing/treatment of AIDS or HIV; or treatment of psychiatric conditions. The above-named medical practice has kept the information in my medical record in strict confidence. This information is being released at my request. I also understand that the above-named medical practice cannot be held responsible for how this information is used once it is released.

I hereby authorize release of my medical records to: ____

____

____

THE PURPOSE OF THIS RELEASE IS FOR:

_____ Treatment by another health care provider

_____ Determining eligibility for insurance

_____ Liability claim

_____ Insurance reimbursement

_____ Transfer

A. INFORMATION TO BE RELEASED:

_____ Entire record

_____ Other: ____

B. I have carefully read this form and I wish to have the designated medical information released, including that CONCERNING ANY SENSITIVE INFORMATION DISCUSSED WITH MY PROVIDER SUCH AS DRUG/SUBSTANCE ABUSE, AID OR HIV, OR PSYCHIATRIC CONDITIONS. I will not hold this medical practice, its health care providers, or Chalfont Family Practice responsible for any misuse of this information, which my occur.

C. I hereby authorize this medical practice to send facsimile by telephone (fax) my medical records. I will not hold this practice responsible for any/all miss-transmission of the same.

_________________________ ____

Date Signature (Patient or Guardian)

____

Witness