CHALFONT FAMILY PRACTICE
65 E BUTLER AVE STE 201
NEW BRITAIN, PA 18901
PHONE 215-822-3113 FAX 215-822-0889

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

_____

PATIENT NAME (Please Print) DATE OF BIRTH

_____

ADDRESS (Street, City, State and Zip Code) PHONE (Area Code and Number)

I, the undersigned, authorize the disclosure/use of the above named patient's health information.

To:

_____

FULL NAME OF INDIVIDUAL OR ENTITY

_____

ADDRESS (Street, City, State, and Zip Code)

_____

PHONE (Area Code and Number) FAX (Area Code and Number)

From: Chalfont Family Practice
65 E Butler Avenue, Suite 201
New Britain, PA 18901

I request that the following health information be disclosed. (Please check all that apply)

___ Complete Medical Record ___ Progress/Visit Notes ___ Imaging Reports
___ Complete Billing Record ___ Consultation Reports ___ Laboratory Results
___ History and Physical Exams ___ Operative/Procedure Reports ___ Pathology Results
___ Other (Please Specify) _____

Covering the period of health care from : _____to: _____
DATE DATE

I authorize Chalfont Family Practice to disclose information relating to psychiatric condition(s), alcohol and or drug abuse, and HIV/AIDS in accordance with Federal confidentiality rules.

____ Yes _____No

_____

SIGNATURE OF PATIENT/LEGAL GUARDIAN/LEGAL REPRESENTATIVE DATE

_____

NAME OF LEGAL GUARDIAN/LEGAL REPRESENTATIVE (Please Print) RELATIONSHIP TO PATIENT