Ninth Street Internal Medicine- AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

805 Locust Street. Philadelphia, PA 19107 Office (215) 440-8681 Fax (215) 440-9953

______________________________	______________________________
(**Print** Patients Full Name)	Birth Date (Mo/Day/Yr)
______________________________	______________________________
Street Address	Social Security Number
______________________________	______________________________
City, State, Zip	Phone (Home)

At the request of the individual, I ___________________________________, do hereby authorize:
(Patient's Name)

____
Name of Previous Provider

____
Street Address

____
City, State, Zip

TO RELEASE DATES OF: ____

___HISTORY & PHYSICAL
___PROGRESS NOTES (last 2 years)
___DIAGNOSTIC TESTS (e.g. colonoscopy, mammogram)
___LABORATORY REPORTS
___RADIOLOGY REPORTS
___ IMMUNIZATION RECORDS
___PAP SMEAR RESULTS (2 years)
___OTHER ________________________

Initial Below:

____I DO ____I DO NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: *NINTH STREET INTERNAL MEDICINE*

PURPOSE OF DISCLOSURE:

____REFERRAL TO SPECIALIST
✓___CHANGE OF DOCTOR
____PERSONAL
____INSURANCE
____LEGAL INVESTIGATION
____CONTINUING CARE
____WORKERS COMP
____DISABILITY DETERMINATION
____OTHER (SPECIFY) ____

Please provide current telephone number in the event we need to contact you: ____________________

MY RIGHTS:
I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

____ ______________________________

Signature of Individual or Guardian or Personal Representative of Patient's Estate **Date**

Form Date 7/11