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 Phone (Home)

_____
City, State, Zip

At the request of the individual, I _____, do hereby
(Patient's Name)
Authorize **NINTH STREET INTERNAL MEDICINE** to release:
(Name & Address of Facility)

DATES OF _____

____HISTORY & PHYSICAL ____LABORATORY REPORTS ____IMMUNIZATION RECORDS
____PROGRESS NOTES (last 2 years) ____RADIOLOGY REPORTS ____ PAP SMEAR RESULTS (2 years)
____DIAGNOSTIC TESTS (e.g. colonoscopy, mammogram) ____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: _____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip

PURPOSE OF DISCLOSURE:

____REFERRAL TO SPECIALIST ____INSURANCE ____WORKERS COMP
____CHANGE OF DOCTOR ____LEGAL INVESTIGATION ____DISABILITY DETERMINATION
____PERSONAL ____CONTINUING CARE
____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