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:

_____

Name of Company/Agency/Facility/Person

_____

Street Address

_____

City, State, Zip

To Release DATES OF:

_____

___HISTORY & PHYSICAL ___LABORATORY REPORTS ___ IMMUNIZATION RECORDS
___PROGRESS NOTES ___RADIOLOGY REPORTS ___PAP SMEAR RESULTS
___DIAGNOSTIC TESTING (e.g. colonoscopy, mammogram, dexascan, etc.) ___HOSPITAL RECORDS
___OTHER: _____

INFORMATION RELEASE TO: ***NINTH STREET INTERNAL MEDICINE***

PURPOSE OF DISCLOSURE:

____CHANGE OF DOCTOR ____COORDINATION OF PRIMARY CARE ____OTHER (SPECIFY)

_____

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 acknowledge that a copy of this authorization may be used in place of its original. 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 authorization is furnished may not condition its treatment of on the basis of whether or not I sign the authorization.

_____ _____

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

NO DISC PLEASE