PRIMARY CARE ASSOCIATES OF ERIE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____ _____

Print Patient Name | Date of Birth | Social Security #

I HEREBY AUTHORIZE:

_____

(Doctor/Group/Clinic Name)

_____

(Address)

_____

(City) (State) (Zip)

TO RELEASE INFORMATION IN MY MEDICAL RECORDS, PLEASE INCLUDE:

☐ All my medical records INCLUDING mental health/alcohol and/or drug abuse/HIV/STD.

☐ All my medical records EXCLUDING mental health/alcohol and/or drug abuse/HIV/STD.

☐ Specific records _____ Date _____

THESE RECORDS ARE TO BE SENT TO:

_____

_____

_____

FOR THE PURPOSE OF:

☐ Second Opinion ☐ Copy to Family Physician ☐ Insurance Purpose ☐ Relocation

☐ Transfer Care to Another Physician/Practice ☐ Other, please describe _____

This consent is valid for sixty (60) days, unless revoked by me in writing or verbally before the release of the designated information. Information disclosed pursuant to this authorization may be subject to redisclosure by the individual/organization identified above and is no longer protected by federal privacy regulations.

_____ _____

Patient Signature | Date

5035 Peach Street, Erie, PA · Phone: (814) 480-7789 · Fax: (814) 480-7790