PLEASANT RUN FAMILY PHYSICIANS

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RELEASE OF MEDICAL INFORMATION to Pleasant Run Family Physicians

I _____, hereby authorize**,**
Name of Doctor/Facility: _____
Address of Doctor/Facility: _____
Phone Number of Doctor/Facility: _____

to release copies of medical records and other information concerning my diagnosis and treatment, including but not limited to information concerning treatment of drug or alcohol abuse, alcoholism, drug related conditions, HIV testing or treatment of HIV related conditions, psychiatric/psychological conditions. Review of records is also authorized.

The following information may be released or reviewed:

- **( )** Doctors Orders and Progress Notes
- **( )** Immunization Records
- **( )** Lab work
- **( )** X-Ray Reports & Other Testing
- **( )** All Medical Records
- **( )** Other_____

The following information is to be released to: **Pleasant Run Family Physicians**

Purpose for Disclosure: _____

REDISCLOSURE IS PROHIBITED WITHOUT SPECIFIC CONSENT OF THE PERSON TO WHOM IT PERTAINS.

This statement must be signed and dated and may be revoked at any time to the extent action has been taken prior to revocation. This consent will expire sixty (60) days after the date below, or sooner by choice, in which case this consent will expire on: _____.

Patient Name: _____ Patient Signature: _____
Patient DOB: _____
Patient Address: _____
Parent/Legal Guardian authorized to give consent: _____
Relationship to Patient: _____
Today's Date: _____

This form is being disclosed to the above individual/organization for the above stated purpose from records whose confidentiality may be protected by federal law.