

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