Dallas Family Practice
16 Church Street
Dallas, PA 18612
(570) 675-2111 Fax (570) 675-6545

CONSENT FOR RELEASE OF INFORMATION

PATIENT NAME _____ **DATE OF BIRTH** _____

REASON FOR RELEASE RECORDS: _____**Transferring to New Provider** _____ **Copies to Specialist**

(INITIAL) _____ **General Authorization**

(INITIAL) _____ **Specific Request of Drug and Alcohol Abuse Patient**

(INITIAL) _____ **Specific Request of HIV Diagnostic Testing Patient**

(INITIAL) _____ **Specific Request of Psychiatric Patient**

Records released will cover the **LAST TWO YEARS** of pertinent information consisting of:

Office Notes, Immunization Record, Test Results, Consult and Hospital Notes.

OR:

Specific Information: _____

_____

SEND TO: **NAME:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **Zip Code** _____

Phone # _____

Payment is required prior to release of records

2017 Medical Records Reproduction Fee Schedule - ACT 26

Pages 1 - 20 ---------- $ 1.48 per page
Pages 21 - 60 ---------- $ 1.10per page
Pages 61+ ---------- $ .37 per page
+ ACTUAL POSTAGE COST

> I have read and understand the above consent and hereby release Dallas Family Practice, L.L.C. and it's employees from any and all legal responsibilities in connection with this act.

> I understand this consent is subject to written revocation only, at any time except to the extent that the person who is to make the disclosure has already acted in reliance on it.

> This consent will expire in 60 days from the date of signature if not revoked earlier.

_____ _____
Patient Signature Date of Patient Signature

_____ _____
Signature of Responsible Party Date of Responsible Party's Signature

_____ _____
Witness Signature Date of Witness Signature