CONSENT FOR RELEASE OF MEDICAL RECORDS

THE INFORMATION IS TO BE RELEASED TO:

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

_____ **General Authorization**
_____ **Specific Request of Drug and Alcohol Abuse Patient**
_____ **Specific Request of HIV Diagnostic Testing Patient**
_____ **Specific Request of Psychiatric Patient**

INFORMATION TO BE RELEASED TO INCLUDE

~ **2 Years of Progress Notes**
~ **2 Years of Labs / X-rays**
~ **Immunization Records**
~ **All Procedure Notes**
~ **All Imagining Reports**

Specific Information _____

I hereby request and authorize :

Facility Name: _____
Address: _____
_____
_____
Phone # : ( ) _____
Fax # : ( ) _____

I authorize you to release the medical records of:

_____ _____
PATIENT NAME **DATE OF BIRTH**

> 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