Fornance Physician Services, Inc.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

______________________________	______________________________
Patient's Full Name	Birth Date
______________________________	______________________________
Street Address	Social Security Number
______________________________	______________________________
City, State, Zip Code	Telephone Number

I ___________________________, do hereby authorize ____,
to release:

Dates of:__________________________

_____Discharge Summary	_____Pathology Reports	_____Emergency Reports
_____History & Physical	_____Laboratory Reports	_____Financial/Billing Documentation
_____Progress Notes	_____Radiology Reports	_____Other
_____Operative Notes	_____EKG/Cardiac Catherization	

_____I do _____I do NOT authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection.
_____I do _____I do NOT authorize the release of information related to psychiatric care and or psychological assessment.
_____I do _____I do NOT authorize the release of information related to treatment for alcohol and or drug abuse.

INFORMATION RELEASE TO:

____
Name of Company/Agency/Facility/Person

____
Street Address

____
City, State, Zip Code

PURPOSE OF DISCLOSURE:

_____Referral to Specialist	_____Insurance	_____Workers Comp	_____Continuing of Care
_____Legal Investigation	_____Disability Determination	_____Personal	_____***Change of Doctor (see back of form)**

Other (Specify)____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 90 days from the date of signature. I understand that I may cancel this request with written notification, but it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorization is furnished may not condition its treatment of me whether or not I sign the authorization.

Note: "This information has been disclosed to you from records whose confidentiality is protected form disclosure by state and federal law. PA Act 148, Section 7111 Pa Mental Health Act, ORC 5122.31, 45 CFR Part 2, and or ORC 3701.243 prohibit you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is not sufficient for this purpose."

____ ________________________________
Signature of individual/Guardian/Personal Representative of the Patient **Date**

____
Printed Name

If this information has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

____

_____________________________________ __________________________ ______________
Witness Signature Print Name Date

NOTE: ***There will be a charge for a personal copy or the permanent transfer of your records. The practice's policy for transfer is to release all records including immunizations, diagnosis history list, medication list, office notes from the past two years, all diagnostics, and all specialist correspondence. The maximum amount charged is regulated by Pennsylvamia Law/PA statute 42PACSA Section 6152. The office can provide updated per page fees. A total amount can not be determined until the number of pages to be copied is known.***