DALLASTOWN MEDICAL ASSOCIATES, LLP
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Authorization for Release of Medical Information

***If faxing complete medical records to our office, please fax overnight.**

Print Patient's Full Name: _____

Date of Birth: _____ Patient's Phone #: _____

I hereby authorize: **Dallastown Medical Associates, L.L.P**.
Please check one: ___Receive from: ____Disclose to:

_____
(Complete name and address of person, physician, or organization that is to receive or disclose information.)

_____

Please Release the Following Records: Please check all that apply.

Dates of service: _____
___Complete History and Physical Examination
___Progress/Office Notes
___Hospital Discharge Summary
___Records from Providers: _____
(Provider Name)

___Complete Medical Records
___ Imaging Reports
___ Consultations
___Laboratory Reports
___Immunizations
___Other_____
(Please Specify)

I understand that the information released may contain:

1. My diagnosis and /or treatment for alcoholism and /or drug abuse dependence in accordance with Federal Public Law 93-282 and/or code of Federal law Regulation 42.
2. My diagnosis and/or treatment concerning my mental health/rehabilitation in accordance with PA Law Act 63 and/ or PA Law PL. 817.
3. HIV related treatment and or testing – Positive or Negative in accordance with ACTn148.

I understand that the information disclosed from this authorization might be re-disclosed by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act if the recipient is not a covered entity.

I understand that this information may be revoked by me, through written notification, at any time, except for any action, which has already been taken. The requester of this information may not condition treatment or coverage on the patient or person providing the authorization. This authorization shall remain in effect and valid for one year.

Please check the reason for release: ____Transfer ____Continuing Care ____Insurance ____Consult
____Referral ____Legal ____Other: _____
(Please Specify)

_____ _____
Signature of Patient/ Responsible Party Relationship to Patient

_____ _____
Witness Signature *Date*

Note: Unless otherwise approved, the records will be mailed to your new physician.
For patients who are changing physicians there will be a $15.00 fee for records that are transferred from this office.
This authorization will not be accepted unless it is completed in its entirety. A copy of this form will be accepted in lieu of the original.
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