DANVILLE FAMILY PRACTICE
Timothy B. Eckel, MD
986 Bloom Road
Danville PA 17821-6758
Phone 570-275-3789 - Fax 570-275-6673

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(If under 18 years of age, parent or guardian must sign)

PATIENT'S NAME: _____

PATIENT'S ADDRESS:_____

DATE OF BIRTH: _____ SS#: _____

PHONE: _____

This is an authorization to release any information FROM my medical records

TO: NAME: _____

ADDRESS: _____

_____

INFORMATION REQUESTED:

OUTPATIENT	INPATIENT
___Clinic Notes	___History & Physical
___Laboratory Tests	___Laboratory Tests
___Radiology	___Radiology
___ALL RECORDS	___ALL RECORDS
___Other (specify)	___Discharge Summary
_____	___Consultation
_____	___Other (specify)
_____	_____
_____	_____

Purpose of Request: _____

SPECIAL AUTHORIZATION (ALL THREE MUST BE INITIALED)

( ) My diagnosis and/or treatment for alcoholism and/or drug abuse or dependence may be released to the recipient noted on the above consent.

( ) My diagnosis and/or treatment regarding my mental health/rehabilitation may be released to the recipient noted on the above consent.

( ) My diagnosis and/or treatment for HIV/AIDS may be released to the recipient noted on the above consent.

This release authorization is valid for three months after signature date below and that I may change this, in writing, at any time unless action has already been taken and records released,

Date: _____ Time: _____ Signed: _____

Date: _____ Time: _____ Witness: _____

(If patient is unable to give consent due to a physical condition or age, sign below.)

Date: _____ Time: _____ Signed: _____ Relationship:_____

REV 8/19 (signature of guardian)