Graham Medical Clinic, P.C. Family Medicine

Joseph A. Pion, D.O. Michael P. Van Grouw, P.A.-C 100 South High Street
Jeffrey Harris, M.D. Rose Mary Harris, P.A.-C Newville, PA 17241
Amy Maley, D.O. Lydia K Fry, P.A.-C. Telephone: 717-776-3114
Marlene Ascione, D.O. Fax: 717-776-5020

Authorization for Release of Medical Records

I, _____ Date of Birth _____
(Patient Name)
Patient Address: _____
Patient Phone Number: _____
Patient Insurance: _____
(From) _____ Release To: _____

_____ _____

_____ _____

Any information which may be requested regarding my physical condition and treatment provided.
Specific Information to be Release: _____
Initial below:
_____ **General Authorization:** I understand and acknowledge that his general information allows the health care facility to release all or part of the records indicated above for the purposes stated.
_____ **Special Authorization:** I understand that my medical records may contain alcohol/drug abuse/or HIV/AIDS and or psychological records. I also give my consent to release this information to the person r facility stated above.

This consent is valid for 90 days unless the release is revoked by me in writing before the release of information. I understand that in a transfer of records to another physician (unless for consult or insurance purposes), I am not a patient at Graham Medical Clinic.

Are you transferring your care to another physician? Yes _____ No _____

I have read this form, or had it read to me, and I understand it. I was given the opportunity to ask questions and they were answered to my satisfaction.
My signature below indicates authorization for release of my medical records.

Signature of Patient: _____

If the patient is a minor or unable to sign for themselves:
Signature of designated individual: _____

Relationship to the patient: _____

Date: _____ **Release Expires:** _____