Easton Family Practice
1901 Hay Terrace
Suite 5
Easton, PA 18042

REQUEST FOR RELEASE OF MEDICAL RECORDS

Dear Dr. ________________________,

This is a written authorization to release my medical records to Easton Family Practice.

I, _____________________________________, authorize any physician, nurse, or other health care professional who has attended me, or any hospital at which I have been confined, to furnish Easton Family Practice, or any authorized representative, any and all information that may be requested regarding my physical or mental condition and treatment rendered there.

Please mail records to:

Easton Family Practice
1901 Hay Terrace
Suite 5
Easton, PA 18042

Information Needed:

_____ All Records
_____ Hospital Discharge Summary
_____ Labs
_____ HIV Results
_____ Hospital Stay
_____ Immunization
_____ Operative Report
_____ Pathology Report
_____ Psychiatric/ Psychotherapy Records

Patient/Guardian Signature: ____________________________________
Date: _____________