PA 1-888-399-0329 | Fax: 888-371-6433

PA Green Medical
1150 1st Ave Suite 950 King of Prussia, PA 19406

Mail to the above address, or Fax copies of Medical Records to 888-371-6433

RELEASE OF INFORMATION AUTHORIZATION

Date Sent:_____
Patient Name:_____

Date of Birth: _____

Last 4 of SS#: _____
Records Requested from Dr. _____

Doctors Phone: _____
Doctor's Fax: _____

Information requested for continuum of care:

- Diagnosis / Problem List
- Medication List
- History & Physical
- Physician Progress Notes

Date of Service: Previous 12 months Only

I authorize release of the health information described above and understand that:

1. Information disclosed pursuant to this Consent/Authorization, may include information relating to sexually transmitted disease, AIDS/HIV, and physiological or psychiatric, conditions, unless restricted as follows:

2. Once information if disclosed pursuant to this Consent/Authorization, I understand that the federal privacy laws(45 C.F.R. parts 160 and 164) protecting health information may not apply to the recipient of the information and therefore may not prohibit the recipient from disclosing.
3. I may revoke this Consent/Authorization at any time, expect to the extent that action has been taken in reliance on it. To revoke it, I must provide the Privacy Officer at the address listed at the top of this form with a written revocation which will not be effective until received and approved be the Privacy Officer.

4. I may refuse to sign this Consent/Authorization and this refusal will not affect the care provided to the patient, unless the patient is seeking health care services solely for the purpose of creating health information for disclosure to a third party.

Patient Signature: _____ Date: _____