ABINGTON SURGICAL CENTER
We're in this together.

PLEASE COMPLETE AND MAIL OR FAX BACK TO 215-957-0565. THANK YOU.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

All items must be completed for this authorization to be valid

(PRINT)
Patient's Name _____ Date of Birth _____

Address: _____ Phone # _____

Please advise if you want the records: ☐ Mailed ☐ Will pick up.

THE UNDERSIGNED AUTHORIZES THE RELEASE OF MEDICAL RECORDS TO:

(NOTE: MEDICAL RECORDS WILL BE RELEASED TO PATIENT OR PHYSICIAN ONLY)

Name: _____

Address: _____

_____

For the purpose of: _____
Approximate dates of treatment: _____
Type of information requested: _____
_____

I authorize the above named source to release or disclose the following information: Any medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition(s), including psychological or psychiatric condition(s), alcohol and/or drug abuse, or any HIV-related information; (In accordance with Federal confidentiality rules (42 CFT Part 2), State Mental Health Procedures Act and Act 148).

If there are any limitations to this list of information, please specify: _____

I understand this consent can be revoked at any time except to the extent that disclosure has already occurred in reliance on this request. Otherwise, this authorization shall remain in effect for the period of ninety (90) days from the date of my signature.

_____/_____/_____
Signature of Patient/Legal Guardian/Legal Representative | Relationship to Patient | Date

_____ _____
Signature of Witness | Date

If a person who is physically unable to provide a signature desires to consent to this release, print his or her name on the appropriate line on page 1 and record below the signatures of two responsible persons who witness that such person understands the nature of his release and freely gave his or her consent.

_____ _____
(Witness) (Witness)

_____ _____
(Date) (Date)

FEDERAL AND/OR STATE LAW PROHIBITS THE REDISCLOSURE OF THIS INFORMATION

2701 Blair Mill Road
Suite 35
Willow Grove, PA 19090

Phone - 215-443-8505
Fax - 215-957-0565