ABINGTON SURGICAL CENTER

We're in this together.

2701 Blair Mill Road · Suite 35 · Willow Grove, PA 19090
Phone: 215 443-8505
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AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

All items must be completed for this authorization to be valid

ABINGTON SURGICAL CENTER WILL RELEASE MEDICAL RECORDS TO PATIENTS OR PHYSICIANS ONLY

(Print)

Patient's Name: _____ Date of Birth _____

Address: _____ Phone # _____

_____

IF YOU WISH RECORDS TO GO TO A PHYSICIAN, PLEASE FILL IN BELOW

Physician Name: _____ Fax: _____

Address: _____

_____

For the purpose of: _____ Approximate dates of treatment: _____

Type of information requested: _____

I authorize Abington Surgical Center 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 limitation 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 one year 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 and record below the signatures of the two responsible persons who witness that such a person understands the nature of this release and freely gave his or her consent.

_____ _____

(Witness) (Witness)

_____ _____

(Date) (Date)