HATBORO MEDICAL ASSOCIATES, P.C.
345 N York Road,
Hatboro, PA 19040
Phone: (215) 675-1516 Fax: (215) 675-9176
INFO@HATBOROMEDICAL.COM

REQUEST TO RELEASE MEDICAL RECORDS

I ________________________________, DOB ____________ hereby authorize

HATBORO MEDICAL ASSOCIATES, P.C. to release the following medical records to:

____

(Name of practice or institution) address/phone/fax number

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- 3 years of Office Visits
- 3 years of Lab Results
- Immunization Records
- Most Recent EKG
- Most Recent Stress Test
- Most Recent Mammogram
- Most Recent Dexa Scan
- Most Recent Colonoscopy

I understand that the information in my health record might include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV). It may also include information about behavior or mental health services, genetic testing, and treatment for alcohol and drug abuse. This information will be released unless otherwise indicated: DO NOT RELEASE ______________ (initials)
I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to information that has been released to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in six (6) months. I understand that requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulation.

____ ___________________________

Signature of patient **Date**