HATBORO MEDICAL ASSOCIATES, P.C.
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REQUEST TO OBTAIN MEDICAL RECORDS

I _____, DOB _____ hereby authorize

_____
(Physician and/or institution) address/ phone or fax number

TO RELEASE THE FOLLOWING MEDICAL RECORDS TO: **HATBORO MEDICAL ASSOCIATES, P.C.**

- 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**