AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

PATIENT'S NAME _____ Birthdate _____
First MI Last

Are medical records filed under another name? _____ Phone Number _____

I HEREBY AUTHORIZE: (Office or Facility Name)

_____

TO RELEASE MEDICAL INFORMATION TO:

D'nese Sokolowski, M.D.
2895 Hamilton Boulevard
Suite 204
Allentown, PA 18104

Please send the following specific information concerning my illness and/or treatment in your facility:

[ ] All records to include sensitive information such as HIV, AIDS, substance abuse, psychiatric or psychological information
[ ] All records within the last 3 years
[ ] Records of HIV disease, mental illness, drug/alcohol abuse, and /or sexually transmitted disease treatment
[ ] X-rays/Films
[ ] Other: [indicate specific illness, procedure, date(s) of treatment, etc.]

_____

_____

I hereby consent to the release of the above information. You are authorized to release to the person or entity above all information or medical records relating to diagnosis, testing or treatment for such disease(s) as specified above. I understand that such information cannot be released without my informed consent. I understand I may cancel this release, in writing, at any time unless the information has been sent. This authorization will expire twelve (12) months from the date below.

PATIENT'S SIGNATURE _____ Date _____

PARENTAL REQUEST FOR CHILD'S MEDICAL RECORDS: I hereby declare under penalty of perjury that I am the natural or adoptive parent or legal guardian of said child and there is no court order restricting or prohibiting my access to such medical records.

PARENT OR LEGAL GUARDIAN _____ Date _____

Date Completed _____ by _____

_____