

Family Medicine Specialists of Jennersville  
1011 West Baltimore Pike  
West Grove, PA 19390  
610-869-8919

Records Release—HIPAA Compliant

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No: \_\_\_\_\_

I authorize the use and disclosure of the above-named individual's health information described below. *Please check one.*

- Family Medicine Specialists of Jennersville** is authorized to release the above-named individual's health information to the following individual(s). **A copy fee may be charged. Please see attached policy.**
- The following individual(s) or organization(s) are authorized to make the disclosure **to Family Medicine Specialists of Jennersville-- Robert P. Denitzio, M.D.**

Name \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

The type of information to be used or disclosed (requested) is as follows:

- Problem list
- Medication list
- List of allergies
- Immunization records
- Most recent history/diagnosis
- Discharge summary for admission on \_\_\_\_\_
- Lab results (list specific tests and dates) \_\_\_\_\_
- Psychotherapy notes
- Entire record \_\_\_\_\_
- Other (please specify)
- X-Ray and imaging report (specify dates) \_\_\_\_\_
- Consultation report (specify consulting physician's name and date) \_\_\_\_\_
- Operative report: Procedure \_\_\_\_\_ Date \_\_\_\_\_
- Progress notes: Range of Dates: \_\_\_\_\_

The following information is protected by state and federal law. If any of this information applies to you, please indicate any or all information you would like released.

- Alcohol or drug abuse treatment records
- Psychiatric treatment
- HIV Treatment

The information for which I am requesting disclosure will be used for the following purpose:

- My personal use
- To evaluate my eligibility for life insurance coverage
- To evaluate my eligibility for disability benefits
- At the request of my attorney: Name \_\_\_\_\_
- Insurance (psychiatry)
- New Physician
- Other (please describe) \_\_\_\_\_

I understand that I have the following rights:

**Right not to sign.** You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by Family Medicine Specialists, except when health services are solely for the purpose of reporting to a third party. An example is a pre-employment physical.

**Right to revoke.** You may revoke this authorization at any time. Your revocation will not apply to any release we have already made in response to this authorization. To revoke this authorization, you must submit a written revocation to our privacy office at the following address:

Family Medicine Specialists of Jennersville, Attention: Privacy Officer, 1011 West Baltimore Pike, West Grove, PA 19390

**Re-disclosure.** I understand that once the information listed above has been disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

Expiration date or event \_\_\_\_\_

**I have read and understand this authorization, and authorize the use and/or disclosure of the health information as described in this authorization.**

\_\_\_\_\_  
Signature of patient (or personal representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of personal representative

\_\_\_\_\_  
Relationship to patient