MADH
Nephrology
Hypertension

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Record Release
Protected Health Information

TO WHOM IT MAY CONCERN:

I am requesting copies of my records from Dr. _____. Please forward them to:

_____

_____

_____

I _____ authorize Dr. _____ to release copies of my records to my care and I will be responsible to forward them to whom I wish.

Any information including the diagnosis and records of any treatment or examination rendered to me during the period from _____ to _____.

_____ _____
Signature of Patient or Guardian **Date**

_____
Witness

Since records for Mental Health, Drug & Alcohol, and HIV/Aids are not covered under a general authorization, these records have been specifically requested as indicated by the patient or Guardian's signature below.
<u>This release is valid for 6 months from the signature date, unless a revocation of consent is signed.</u>

_____
Signature of Patient or Guardian

_____
Witness

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West Chester, PA 19380

100 West Sproul Road, Suite 224
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