Lehigh Family & Geriatric Associates
428 South 7th Street
Lehighton PA 18235
Phone: (610) 824-8350
FAX:(610)824-8351

Authorization to Release Medical Records

Patient's Name:_____ Date of Birth:____/____/_____
(Please Print)

Address:_____ Telephone No.(____)_____
Street City State Zip

I hereby authorize:

_____(____)_____
Name of Person or Facility Telephone No.

_____
Street City State Zip

To release protected health information, including copies of the medical record of the above-named patient, to Lehigh Family & Geriatric Associates.

INFORMATION TO BE DISCLOSED: From (date):_____ To (date):_____
__Complete Health Records(s) __Laboratory Tests
__Radiology Reports __Immunization Records
__Other (Please specify)

PURPOSE OF REQUEST: *Processing fees may apply.*
__Transfer of Medical Care __Insurance Purposes
__Attorney __Personal Copy (for a fee)
__Continuity of Medical Care for referrals, consultations, test(s) or treatment
__Other:_____

PSYCHIATRIC, DRUG AND/OR ALCOHOL ABUSE, HIV/AIDS OR OTHER COMMUNICABLE DISEASE RELEASE:

I agree that any information regarding Psychiatric, Drug/Alcohol Abuse, HIV/AIDS or Communicable Disease may be released:_____YES(initial) _____NO(initial)

This authorization will automatically expire 90 days from the date set forth below unless otherwise specified:_____
(date of expiration)

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Printed Name of Patient or Authorized Representative* Relationship to Patient

_____
Witness Signature