DUBLIN MEDICAL CENTER
FAMILY MEDICINE

ROBERT A. DAVIS, MD *Family Practice*
Robert A. Davis, MD
Joy M. Davis, MSN, CRNP
Natasha L. Worthington, PA-C

Patient Signature: _____ **Date:** _____

Authorization for Release of Medical Records

Patient Name:_____
PatientAddress:_____
Patient DOB:_____
Telephone Number:_____

I authorize the records to disclose/release the following information**(Check all applicable)
_____ All Records
_____ Laboratory/Pathology Results
_____ X-ray/Radiology Records
_____ Office Notes
_____ Other: _____

**Note: If these records contain any information about drug/alcohol abuse, sexually transmitted disease, or psychiatric issues, you are hereby authorizing disclosure of this information.

Please release the records FROM:

(Complete name of Person/Organization)

_____
Address

_____
City, State, Zip Code

_____
Phone Number/Fax Number

And send Records TO: Robert A Davis, M.D, Family Practice
P.O Box 450
174 North Main Street
Dublin, PA 18917
Phone: (215)249-9020 Fax: (215)249-3469

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information.

_____ _____
Signature of patient or patient's representative Date