# DUBLIN MEDICAL CENTER

FAMILY MEDICINE

Robert Davis, MD | Joy Davis, CRNP | Natasha Worthington, PA-C

**www.Dublin-Medical.com**

## Authorization for Release of Medical Records

| Patient Information | | | | |
|---|---|---|---|---|
| Last Name | First Name | | Middle Initial | Previous Name (If applicable) |
| Mailing Address | | Apt # | City State | Zip Code |
| Date of Birth | Phone Number | | Email Address | |

| I authorize my medical records to be disclosed / released. | ☐ Yes | ☐ No |
|---|---|---|

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

| Please release my records from: | | | | |
|---|---|---|---|---|
| Organization Name | | | | |
| Address | | Apt # | City State | Zip Code |
| Phone Number | Fax Number | | Email Address | |

Please send records to:

**Robert A Davis, M.D, Family Practice**

**P.O Box 450**

**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.

**Patient or Representative's Signature**

**Date**