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.	Please Initial	
Include last three years of records, including Labs, Radiology, Mammograms, Colon Cancer Screenings, and Immunizations	☐ Yes	☐ No

**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 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

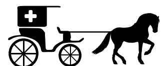
P.O. Box 450

145 North Main St,

Dublin, PA 18917

Phone: (215) 249-9020 | Fax: (215) 249-3469

Email: Office@Dublin-Medical.com



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