DUBLIN MEDICAL CENTER

FAMILY MEDICINE

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

www.Dublin-Medical.com

Authorization for Request 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 (3) years of records, including lifetime record of vaccinations, last ten (10) years of colon cancer screenings, and last three (3) years of Labs, Radiology, Mammograms, and any other relevant testing	☐ 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