WEST SHORE FAMILY PRACTICE, P.C.
6375 MERCURY DRIVE, SUITE 200
MECHANICSBURG, PA 17050
PHONE: 717-620-2500 FAX: 717-620-2511

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient:_____ Soc.Sec. #_____

Street Address:_____ D.O.B. _____

City_____State_____ Zip code_____Phone #: _____

I hereby authorize: _____

_____

_____

Phone: _____Fax:_____

To release my medical records to: **West Shore Family Practice, P.C.**
6375 Mercury Drive, Suite 200
Mechanicsburg, PA 17050

Records are to be released for the purpose of: _____ comprehensive medical care
_____ other:_____.

The following information is protected by state and federal law. **If any of this information applies to me, I have indicated any/or all information that I would liked released (initial all areas applicable):**
_____HIV Testing & Results (Act 148) _____Alcohol or Drug Abuse _____Psychiatric

Specific Information Requested:
_____ All records, including Problem List, Medication List, Immunization Records, Progress Notes, Lab/Pathology Reports, Radiology Reports, Diagnostic Testing Reports, Consult Letters.
_____ Other: _____

Specific Dates of Care covered by this release: From: **First Records** to: **Present**

This authorization shall be valid from _____ **to** _____, but in no event shall this authorization be valid for more than 120 days from the date of signature.

*I have signed this authorization voluntarily; my treatment at West Shore Family Practice is not conditional to signing this release. *I understand that this consent may be revoked by me at any time by presenting a written statement of revocation to West Shore Family Practice. I understand this revocation will not apply to any information that has already been released in response to this authorization. *I also understand that the information disclosed according to this release may be re-disclosed by the recipient and is no longer protected by HIPAA (Federal Regulations).

*I fully understand the nature of this authorization for release of medical information.

_____ **Date:**_____
Signature of patient or legal representative

_____
If signed by legal representative, relationship to patient

Signature of staff person assisting with form:_____Date:_____