Lehigh Valley Family Practice Associates

190 Brodhead Road, Suite 101, Bethlehem, PA 18017

Phone 610-694-9090 *Fax* 610-861-8295

James W. Manley, DO | Eric D. Kane, DO | Nikki Hrycko, CRNP | Lynn Phillips, CRNP

Patient Name_____ **Date of Birth**_____

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND CONFIDENTIAL HIV-RELATED INFORMATION

I, _____, authorize _____,
(patient name) (previous physician name, group name and phone number required)
or an authorized representative, to release photocopies of any and all information that may be requested regarding my physical and/or mental condition and treatment rendered. In addition, I also authorize the release of confidential HIV-related information, psychiatric/psychotherapy records, mental-health records, and drug and alcohol treatment information under the same terms and conditions.

Please release records from _____ to _____.
(start date) (end date)

Records should also include the most recent:
___ ECGs ___ Labs
___ Immunizations ___ Radiology Studies
___ Other _____

I authorize the release of this information to _____ and allow him/her, or any
(new physician or physician group)
physician appointed by him/her, to examine this information.

I understand that this consent is subject to revocation at any time except to the extent that _____,
(previous physician)
or the person/entity making the disclosure, has already acted on it.

This consent will terminate one year from today, on _____, unless I revoke my consent.

A photocopy of this consent may be used instead of the original.

Signature of Patient
Or Legal Representative _____ Relationship to Patient_____ Date_____